

# ANNUAL REPORT & ACCOUNTS

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# 2024-2025



## The Royal Orthopaedic Hospital NHS Foundation Trust



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# **The Royal Orthopaedic Hospital NHS Foundation Trust**

## **Annual Report & Accounts 2024/25**

**Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006**



## Chair and Chief Executive's Foreword

With a backdrop of over 200 years since its establishment, the Royal Orthopaedic Hospital has a rich and proud heritage and strong reputation for delivery of excellent and innovative care across a range of surgical and non-surgical orthopaedic and musculoskeletal (MSK) services. Before reflecting on the past year, it is important to recognise that the future focus for the organisation is with clarity, optimism and ambition. The Trust will continue to offer the highest quality of treatment, exceptional patient experience and the first-rate levels of staff experience, while embracing what will be an exciting but nonetheless, challenging era for the NHS as the national focus on the fundamentals of patient care changes and adapts to the national context and public need.

Reflecting on the past year, we have seen a change in Government and new NHS leadership, which commissioned the report by Lord Ara Darzi into the state of the NHS, this being published in the Autumn of 2024. The report centred on the need to rebuild the trust and confidence of the public in the NHS, but crucially suggested three fundamental shifts in focus for the NHS: sickness to prevention; hospital to community; and analogue to digital. Together, these create a greater focus on hospital avoidance, but also a real emphasis on efficiency & productivity. With this in mind, a major piece of work undertaken during the year, has been to refresh our five-year strategy, refocussing the delivery plan and priorities to reflect the changing external environment. It is imperative that the ROH operates in a way that continues to offer stability and sustainability and therefore the measures needed to ensure that care is delivered as productively and efficiently as possible will be front and centre as we enter the new year. As well as continuing to operate in line with our core purpose, the Trust will also focus more closely on its contribution to the prevention agenda and its role in the delivery of care at the centre of the local communities.

One of the most positive changes that we have seen develop in the last few years, is the benefit of collaborative working across and within regions, a result largely due to the advent of the Integrated Care Boards and the introduction of the legal duty on Provider organisations to work together within these frameworks. The Trust has continued to be an active member of the Birmingham and Solihull (BSol) system over the year and has worked closely with local partners to support pathways of care that ensure that citizens of the region and beyond are treated as quickly and as effectively as possible through the development of mutual aid arrangements; approximately 400 people have been treated this year, through this arrangement, transferred to us from BSol partners, but also from organisations further afield, including Robert Jones & Agnes Hunt NHSFT, University Hospitals of the North Midlands and NHS Trust and Shrewsbury & Telford NHS Trust. We are incredibly proud of the dedication we have seen from our staff and of some of the incredible achievements that have been delivered over the past year to ensure that the patients we serve receive timely, excellent and high-quality care.

Work will continue over 2025/26 to support the development and embed the Acute Provider Collaborative, lowering the boundary walls between providers within the System and ensuring that the care offered is by those with the most appropriate expertise. During the year, the Trust has also joined the BSol Community Care Collaborative, this being established very much with the Darzi recommendations in mind, overseeing and driving the development of integrated care in neighbourhoods and localities that helps people to stay as healthy as possible in their own communities. This work is in its infancy, but there is a real drive and passion to move this forward as we enter the new financial year; the contribution that MSK services, led by the ROH, can make to this work, is unquestionably significant. The work in the community has been further developed by the Trust's participation in a series of MSK Community Appointment Days, where we were joined by colleagues from across the BSol System at various accessible locations within the area, to provide patients waiting for physiotherapy treatment the opportunity to connect with a variety of clinical and voluntary sector support services. This approach, together with leading for BSol the national 'MSK Community Waits Further Faster Programme' has seen waiting times for over 3,000 patients who have been waiting in excess of 18 weeks for treatment, reduce.

We have continued to work closely with partnerships forged during the last few years, including Birmingham Health Partners (BHP) and the Federation of Specialist Hospitals (FoSH). The Trust provided significant input to the work undertaken by FoSH to respond to the consultation on the national 10-year Health Plan and to develop and launch in Parliament, its report 'The Power of Specialism in the Future NHS'. This calls on policymakers to recognise the unique role of specialist hospitals, and the benefits that they can bring to the wider health system when designing the national health service of the future. Work has been initiated during the year on some innovative work with local educational establishments and industry partners through the Warwick Health and Wellbeing Innovation Accelerator, including

considering how Artificial Intelligence (AI) may support the Trust's processes. Other key relationships formed during the year included those with Birmingham Life Sciences Innovation Hub and Health Innovation West Midlands, both offering opportunities to develop and explore new and exciting ways of delivering care to our population. We visited Jaguar Land Rover in April 2024, to understand their wellbeing offering to staff and to have initial conversations around how we might mutually support each other; it is anticipated that these discussions and ideas will develop as we move through the coming year.

In 2024/25, we welcomed a number of other visitors to the Trust, including Professor Aleks Subic, Vice Chancellor & Chief Executive of Aston University, to understand how the University and ROH could work more closely together for the benefit of local citizens, patients and individuals studying for a career in the medical field. We also met with Richard Burden and Andy Cave, the Chair and Chief Executive of Birmingham Healthwatch in October and discussed ways in which there may be benefits to working together, particularly around patient feedback and support.

The Trust has continued to operate as a Major Revision Centre and build on its success as a NHS England 'Getting it Right First Time' (GIRFT) Surgical Elective Hub. The Trust underwent its annual accreditation by the GIRFT team on 31 July 2024 and again, was complimented for the high quality of care offered and sound arrangements in place to deliver elective services.

We hosted two significant cancer peer reviews during the year, with NHS England's Specialised Commissioning Quality & Nursing Team facilitating a review of the Trust's Primary Malignant Bone Tumour Service (PMBTS) in July 2024; this received a positive outcome and some pleasing feedback, including 'a remarkable service with extremely high standards'. In September 2024, the Trust underwent a review of its Teenage and Young Adult cancer service. Again, feedback was very positive, with comments being that the team had seen 'fantastic performance and a well organised service'.

The Trust was proud to host and participate in some prestigious conferences and events during the year, including the Caribbean Nurses & Midwives Association UK conference in June 2024 and the inaugural conference to launch the development of a Women's Health Strategy for the BSol Women's Health Hub. Closer to home, the ROH held its inaugural Orthopaedic Nursing and Allied Health Professionals Conference in April 2024.

The ROH has continued to see the development of its estate over the past year, with the upgrade and expansion of the Oncology and Appointments facilities. Further work is planned in 2025/26, particularly to maximise the efficiency of our operating theatres.

The Trust did not receive an inspection by the CQC during the year, however we developed our links with a new CQC relationship team assigned to the Trust. We hosted one of the inspectors for a visit on 9 October 2024 and took the opportunity to showcase some of services we offer, including the pioneering 'GetuBetter' technology, together with the work that has been undertaken around the new Service Accreditation process and the implementation of the recent Patient Safety Incident Response Framework. Work continues to prepare for the next assessment by the CQC including self-assessing ourselves against the key domains of the CQC's Single Assessment Framework. The Trust remains at a 'Good' rating across all domains of the CQC framework, which reflects the outcome of the last formal assessment in 2019. Over the summer 2024, we received with pride, the latest CQC national impatient survey results, which again rate us as one of the handful of trusts performing as 'Much Better than Expected', with notably good scores around admission to and leaving from hospital, feedback on care by clinical staff and overall experience.

Towards the end of the year, we saw the publication of the National Staff Survey results, which positioned the Trust positively against many other NHS organisations, particularly in terms of flexible working, the welcome of the sexual safety charter and staff feeling safe at work. Disappointingly, however, the number of staff indicating that they believe that they experience discrimination as a result of their ethnic background and staff feeling that they did not receive a good quality appraisal is too high. We are taking these results very seriously and must do better over the coming year to understand the issues and take action to ensure that staff feel they are treated equally and receive a meaningful appraisal that supports their development.

The focus on staff feeling safe from discrimination is incredibly important, particularly given the aftermath of the tragic child deaths in Southport last year, where many individuals from an ethnic background suffered abuse, both physically and verbally. The Trust's stance, as it always has been, is to operate with a zero tolerance approach to any form of detrimental treatment to its staff, patients and visitors. Much work is planned in 2025/26 to embed a culture of antiracism, building on the work that we started last year to work through the Race Equality Code.

There has been a keen focus on staff development and support this year, including the ongoing 'Leaders Who Care' programme for senior staff, and the introduction of the Preceptorship programme for our nursing colleagues. The new 'Me as a Manager' programme will launch in 2025/26 providing a new and innovative way of upskilling those in leadership positions.

In terms of the Board and Executive Team composition, there have been some key changes during the year. The most significant change has been to welcome Matthew Hartland as our Chief Executive, while Jo Williams is on secondment at Shrewsbury & Telford Hospitals Trust. We have also been joined by a new Non Executive colleague, Jan Teo, who started with the Board in April 2024. Both Matthew and Jan are wished well and every success for their time at the ROH.

We marked the departure of some of our other key colleagues to retirement, with two of our particularly long serving staff leaving us: Sandra Millward, Head of Imaging and Evelyn O'Kane, Safeguarding Lead leaving us. We thank these and all other staff that left us during the year, for their years of service and contribution to the ROH.

Although we have seen some departures, we have been fortunate to have been joined in the year by a significant number of new staff into key positions. We have been fortunate to attract some very talented new medical staff into the Trust, which have joined the spinal, oncology, arthroscopy anaesthetic and small joints departments.

In terms of the Council of Governors, there were a number of changes, as we said goodbye to Petro Nicolaides and Pat Clarke, public governors and Wilson Thomas, staff governor. We were pleased that Arthur Hughes, public governor was re-elected and also welcomed Gareth Yeomans, another public governor to the ROH. Two new staff governors took up post during the year: Izzy Munford and Jack Ellis. The Annual General Meeting was held on 20 November 2024 and was attended by a number of staff, governors and members.

During 2024/25, the ROH hosted some key celebrations in its true style. June was a busy month at the ROH and a particularly significant celebration this year centred around the 80<sup>th</sup> anniversary of the D-Day landings, marking the beginning of the liberation of Western Europe from the Second World War. A service of remembrance was held to mark the occasion and to remember the period of history, vintage singers performed songs from the war, the canteen served food from the era and the hospital was decked in Union Jack bunting. The 'Blue Hearts' staff awards ceremony was also held at the Regis Hotel in Birmingham in June, with over 600 nominations received and 190 staff attending the important celebrations. June also saw the long service awards offered to our dedicated staff and also the heartwarming 'thank you' event for our valued volunteers.

As we moved through the year, we celebrated Armed Forces week, LGBTQ+ awareness week, Black History month, Wellbeing week, World Menopause day and Freedom to Speak Up month. The Freedom to Speak Up network has been strengthened this year through the work of the champions and the expansion of the team. We thank them for their endeavours to ensure our staff feel comfortable to raise matters that ensure we keep our patients and ourselves safe and happy in the hospital.

Finally, to round off 2024, staff were pleased to attend the annual Christmas market, with the event welcoming more stalls than in previous years, which provided a positive start to the festive season.

We are delighted with some more accolades that the Trust has received during the year, including the successes of the Finance Team who achieved accreditation with the One NHS Finance: Towards Excellence scheme, where the team was awarded Level 2, this being the highest level of performance. Jo Williams was also awarded an Honorary Doctorate by Aston University, which is testament to links she forged with the local education establishments. Finally, we received excellent news that the Trust had been awarded the National Joint Registry Gold Award, which relates to data collection and compliance. Thanks are offered to our Medical Director, Matthew Revell, for his leadership in this area.

The Trust retained its position as one of the UK's 50 Inclusive Companies, with an improved rating of 8<sup>th</sup> awarded this year, marking us at the most inclusive NHS organisation in the UK – we remain proud of this achievement; there is also pride, as Jo Williams was nominated and awarded as the Chief Executive of the Year by Inclusive Companies, in recognition of the work she has led to focus the Trust on wellbeing and inclusivity.

The Royal Orthopaedic Charity (ROC) saw both successes and challenges in 2024/25, reporting a 65.3% increase in donation but a 21.1% decrease in fundraising revenues. The charity focused on grant applications to fund the procurement of hospital equipment with 8 successful applications equating to £49,588 of funding with more planned in

2025/26. The launch of Health Hacks in May 2024, saw ROC attend a local school with a number of doctors and physiotherapists to educate children on the best ways to stay healthy, active and prevent MSK difficulties. The school then made a return visit to the hospital in the hope of inspiring the next generation around careers in healthcare services. Birmingham City Council has continued to support the ROH pantry, to provide a warm breakfast for all and the 'Blue Bag' project (free sanitary products) through two additional grants of £4,000. As we move to 2025/26, ROC will expand its fundraising in the community by attending more local events and recruiting more supporters who are interested in active events. We also hope to find a new home for the charity that is easily accessible for our patients and staff. As ever, we are extremely proud of the projects and improvements we have enabled, We offer our heartfelt thanks to all those who have chosen to support ROC through a variety of ways, during the last year.

Coming to the end of this summary, we would like to reflect on the challenges and changes, both nationally and locally, that have affected the NHS and ROH during the year. With the shift in focus created by the change in NHS leadership and very ambitious planning requirements for the NHS overall, there have been many challenges which will persist into the coming year. This will require some tough decisions and the adoption of some very different ways of running the organisation, including strengthened controls, governance framework and oversight arrangements, most of which we have already implemented. Equally, however, it is important to celebrate some of the extraordinary achievements that have been made over the last year and to recognise that with the changes we have seen and to come, this brings opportunity to work with innovation and collaboratively with others, building on existing partnership arrangements and making new ones. The ROH is in a strong position because of the talent, dedication and willingness of its staff to adapt and support what change will be necessary as we move into the next year and what will be undoubtedly a very different era for the NHS as a whole.



**Tim Pile, Trust Chair**



**Matthew Hartland, Chief Executive**

A handwritten signature in black ink, appearing to read 'Tim Pile'. The signature is stylized and written in a cursive-like font.

A handwritten signature in black ink, appearing to read 'Matthew Hartland'. The signature is written in a cursive-like font.

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# PERFORMANCE REPORT

## 1.0 Overview

### 1.1 Purpose of the overview section

The purpose of the overview is to provide a short summary to be able to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

### 1.2 Purpose and Activities, Business Model and Organisational Structure

The Royal Orthopaedic Hospital NHS Foundation Trust (ROH, “the Trust”) is one of the largest providers of elective orthopaedic surgery in the UK and is one of five specialist orthopaedic centres. It offers three tiers of service:

- Routine orthopaedic operations for a local population of 3 million people in Birmingham and North Worcestershire;
- Specialist services such as spinal surgery to 5 million people who live in the Birmingham conurbation and the wider West Midlands; and
- Diagnosis and treatment of malignant bone tumours.

The Trust’s annual financial turnover is in the region of £151 million. It has fourteen operating theatres, six wards and 109 beds, including six being on a High Dependency Unit and eight beds for private treatment.

The Trust employs in excess of 1,400 staff, including more than 80 Consultant medical staff, each supported by multi-disciplinary clinical teams including surgeons, nurses, anaesthetists, physiotherapists, radiologists, pathologists, occupational therapists and other clinical professionals.

Only a small amount of emergency and urgent activity is undertaken, generally in the field of spinal disorders; the core business of the ROH is elective surgery. During the financial year covered by this report, the Trust continued to treat cohorts of patients from University Hospitals Birmingham NHSFT (UHB) and a small number of providers outside of the West Midlands, in a mutual aid arrangement to support the national elective recovery imperative and reduce waiting times for those requiring treatment.

The main elective surgery activities are joint replacement surgery (arthroplasty), joint arthroscopy and reconstruction (keyhole surgery and ligament repairs), plus hand and foot surgery. The hospital is accredited as an elective hub, first awarded in 2023 by the national Getting it Right First Time (GIRFT) team.

The hospital provides a specialist bone infection service. The hospital is one of the centres in England for the diagnosis and treatment of malignant bone tumours and the bone tumour service commissioned by specialised commissioning. The Trust is one of 12 centres in England for the treatment of soft tissue sarcomas.

### 1.3 Our Strategy for the Future

We are now two years into the delivery of our Trust strategy (2023-2028). We have achieved some of what we set out to achieve which is commendable, but there is more to do. We have undertaken a mid-term strategic review in 2025 to ensure our strategy remains aligned with a new political and healthcare environment, new policies, and guidance, and reflects the broader challenges around financial and operational performance and workforce requirements. Our refreshed strategy builds on the previous version, retaining the same core objectives and adapting them to reflect our drive towards organisational sustainability and leadership in orthopaedics, both locally and nationally.

This table explains our core strategic objectives and their associated critical success measures:

Strategic objective	Critical success measure
<b>Care</b>	By 2028, we will maintain outstanding, high-quality care across all services and improve access, experience and outcomes for our patients.

<b>Expertise</b>	By 2028, we will have increased our influence as the leading centre for orthopaedic surgery and MSK care through our cutting-edge research and MSK Academy.
<b>People</b>	By 2028, we will be rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey, recognising our commitment towards inclusivity and wellbeing for all.
<b>Community</b>	By 2028, we will be leaders in MSK Prevention across our communities, improving access to our services and increasing the provision of MSK expertise at locality level.
<b>Sustainability</b>	By 2028, the ROH will be financially sustainable, having increased the number of people we treat through continuously improving our processes, standardising pathways and improving productivity.
<b>Collaboration</b>	By 2028, we will have transformed MSK and orthopaedic services for our patient population through our strategic partnerships across healthcare, third sector, industry, research, and academia.

The aim of our Trust Strategy is clear:

- We will grow and treat more people
- We will contribute to reducing health inequality
- We will improve access to care for our community
- We will be rated among the best hospitals to work for
- We will be rated 'outstanding overall' by the CQC
- We will be an efficient and sustainable organisation
- We will be a world-recognised leader in orthopaedics
- We will be in productive partnerships that benefit patients

Our Trust Strategy is supported by a detailed Delivery Plan which includes national metrics we must achieve as well as important Trust targets and transformation initiatives we will undertake. This Delivery Plan is aligned with departmental annual business plans to ensure that our efforts are complimentary. There are also six key enabling plans which will support strategic delivery:

- Digital, Data & Technology Plan
- People Plan
- Prevention Plan
- Research and Development Plan
- Commercial Plan
- Estates Plan

The delivery of our Trust Strategy, Delivery Plan, annual business plans and key enabling plans will be regularly monitored by the Trust Board to support assurance and delivery.

The Trust Strategy contains a range of metrics associated with strategic delivery. These will be monitored monthly by the Trust Board, ensuring that we meet our strategic ambition.

We continue to work collaboratively with partners in Birmingham and Solihull Integrated Care System (BSol ICS, 'the system'). Notably, we are leading the transformation of local Musculoskeletal (MSK) Services which aims to standardise MSK pathways, support self-management, reduce variation and improve access. We are ambitious about the potential this programme offers to support the reduction of health inequality. We are also working with System partners through the Acute Provider Collaborative, to transform how elective orthopaedic surgery is delivered locally.

The Trust shows due regard for the guidance published by NHS England around the duty to collaborate. Although the ROH is not a member of the Board of the BSol ICB, it is represented as a provider as a member of the Acute Provider Collaborative. Most of the ROH Board members are included within the membership of various System meetings, some of which are comprised of equivalent colleagues from across the System, such as joint Chief People Officer, joint Chief Finance Officer and joint Chief Operating Officers fora. The System Chief Executives also meet weekly in a forum chaired by the Chief Executive of the Integrated Care Board and the Trust Chair represents the ROH at the BSol Integrated Care Partnership (ICP) meetings. During the year, sessions were held to which all Executives and Chief Executives from all Provider organisations and the ICB were invited. It is through these forums that agreements on how the System strategy and plans are executed is reached. Some of these joint meetings are also used to discuss and agree financial allocations where relevant such as capital funding, the plans then requiring local approval by the constituent boards of individual organisations. Some of the ROH Non Executives are also active participants in the Boards and Committees of other local ICBs.

We are planning for, and are enthusiastic about, the future. We are excited to continue delivering outstanding care to our communities, underpinned by the values which drive us.

## 1.4 Brief History and Statutory Background

The ROH is situated in the south of Birmingham, five miles from Birmingham City Centre. It provides services mainly to the population of Birmingham and the West Midlands but also offers a national service for a number of specialities.

The ROH was established on 17 June 1817 when a committee, chaired by the Earl of Dartmouth, was established to provide a "general institution for the relief of persons labouring under bodily deformity." It became a foundation trust in 2007.

The Trust is part of the National Orthopaedic Alliance (NOA). The NOA is an acute care collaboration providing a framework for improving quality in orthopaedic care across England.

The accounts have been prepared under a direction issued by NHS England under the National Health Service Act 2012.

## 1.5 Key Issues, Risks and Opportunities

The Trust manages its internal risks through a Corporate Risk Register and the Board Assurance Framework (BAF), the second of which highlights major risks to the delivery of the Trust's strategic objectives and organisational goals. The BAF is aligned to the six strategic objectives in the Trust's 2023-28 strategy and the key risks identified during the year and discussed by the Board during the year are included within the Annual Governance Statement (AGS) (Section 8).

Further information on the risk appetite of the Trust, key risks on the BAF linked to key performance Indicators of the Trust, their risk score, and mitigating actions can also be found in the AGS.

In terms of opportunities for the future, the Trust intends to continue to lead a fundamental service reconfiguration for orthopaedic and MSK services and working with partners across the System provide leadership for the entire pathway, making best use of current capacity and resources.

## 1.6 Performance Analysis

### 1.6.1 Introduction summary

During 2024/25, the strategic and operational performance of the Trust was delivered through our divisional structure, comprising two clinical divisions (Patient Services and Patient Support Services) and two supporting divisions (Estates & Facilities and Corporate Services). These divisions were responsible for the delivery of safe and effective patient centred care, high quality outcomes and compliance with national and local finance and performance targets. The delivery was aligned to the operational delivery plan and individual business plans. Operational Performance metrics are presented and discussed at the Trust's Finance and Performance Committee monthly. Operational performance metrics are monitored at the Operational Management Board. Specific Projects relating to Operational improvements were also monitored monthly at the Service Improvement board.

The key aim for 2024/25, was to continue to recover elective waiting lists reducing the Referral to Treatment Time (RTT), maintaining the position of zero patients waiting over 78 weeks for treatment and working towards the delivery of zero patients waiting over 65 weeks for treatment by 30<sup>th</sup> September 2024, in line with national operational requirements. The continued delivery and exceeding national targets in Cancer and diagnostic targets were also a key operational aim for 2024/25.

## 1.6.2 Key objectives

During 2024/25 Trusts within the BSol ICB have worked in partnership through a series of interventions to improve operational performance across BSol for Cancer and Elective Recovery. The ROH continued to support UHB operating lists in 2 of its 14 theatres (20 sessions) for Q1 with this reducing to 6 theatre sessions from Q2, as well as accepting patient transfers to improve access and reduce healthcare inequalities. This continued effective collaboration in patient pathways has been noted as excellent practice, demonstrating the benefits of system working for reducing health inequalities for the patients of BSol. The Trust also continued to provide mutual aid of circa 400 patients to Trusts within the region. This capacity used for patients outside of the BSol area was part of the NHSE request for ROH to support a national mutual aid strategy where trusts were recovering well following the impact on waiting lists of Covid 19.

**Key Objectives aligned to Operational Planning guidance were:**

### Electives

- Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties).
- Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%. The Trust's target was to increase elective activity by 6% from 2023/24 to 24/2025 this equated to the delivery of 15,326 cases.
- Improve patients' experience of choice at point of referral.

### Cancer

- Improve performance against the headline 62-day standard to 70% by March 2025.
- Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026.
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

### Diagnostics

- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

## 1.6.3 Operational Performance

The Trust continued to work with the BSol ICB throughout the 2024/25 financial year, adapting and evolving as patient needs were identified as an ICB to deliver quantifiable improvement in elective waiting lists. From July 2022, the Trust has actively participated in BSol System Oversight Groups, weekly meeting to manage elective recovery.

The ROH continued to support UHB operating lists in 2 of its 14 theatres (20 sessions) for Q1 with this reducing to 6 theatre sessions from Q2, as well as accepting patient transfers to improve access and reduce healthcare inequalities. The two trusts continue to foster a close working relationship to maintain a high standard of care within a strong governance framework.

**Activity Undertaken 2024/25**

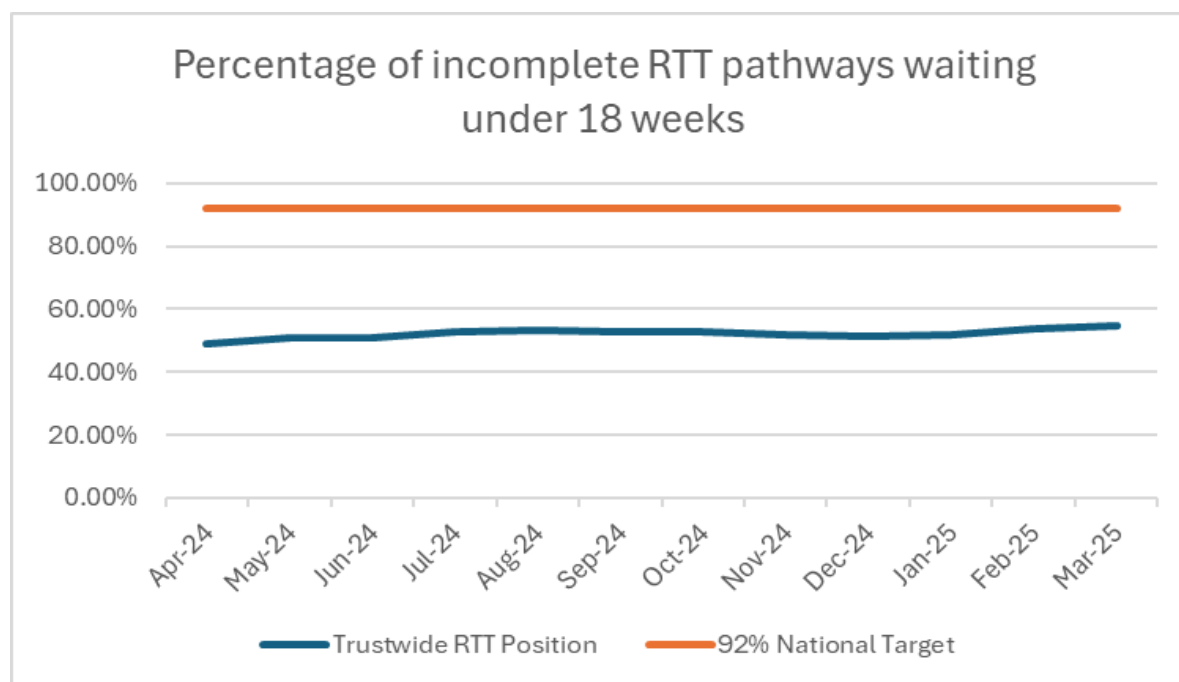
The Trust had an ambitious plan to increase elective activity and productivity during 24/25. In 2024/25 the Trust incurred significant challenges with unplanned theatre downtime, increased acuity and complexity of patients and significant staff vacancies in theatre. However, due to a focussed effort on productivity and performance particularly in Q3/4 the final position for elective activity in 2024/25 was **15,149** against a BSol ICB plan of **15,326**. This was a deficit of **-177** procedures (Circa **-1%** of agreed target). The case mix has seen an increase in relation to day cases in line with national trends, ensuring patients are treated as day cases wherever clinically feasible and the number of patients treated in procedure rooms outside of theatres also increased.

	Actual Treated 2024/25	Actual Treated 2023/24	Actual Treated 2022/23	Actual Treated 2021/22
Inpatients	6,646	6,874	6,353	7,161
Day cases	8,296	7,604	7,210	6,250
<b>Total Admitted Patient Care</b>	<b>15,149</b>	<b>14,478</b>	<b>13,882</b>	<b>13,411</b>
First Appointment	24,484	22,479	18,129	19,219
Follow Up Appointment	48,421	43,566	40,602	40,309
<b>Total Outpatients</b>	<b>72,905</b>	<b>66,045</b>	<b>62,078</b>	<b>61,845</b>

The outpatient activity exceeded plan significantly and increased by **6,806** from **2023/24** delivering a **9%** overperformance overall.

**Referral to Treatment**

The Referral to Treatment (RTT) position for March 2025 is **54.66%** (an improvement of circa 6% compared to March 24 position of **48.58%**) against the national compliance target of treating 92% of patients within 18 weeks of referral. This is reflective of the cumulative impact of growing waiting time pressures within Spinal at a Regional and a National level and the utilisation of capacity to support local and national mutual aid requests. The graphs below represent the changes in Incomplete pathways during 2024/25:



The Trust ended the year with all services delivering zero 65 week waits except for Spinal services with 1 patient over 65 weeks. Arthroplasty, Foot and Ankle, Oncology and Oncology Arthroplasty have all delivered zero 52 weeks and most other specialities (except for Spinal) are very close to delivering zero patients waiting 52 weeks, and we expect to deliver this by the end of April 2025.

Clear trajectories were agreed as part of annual business planning for 2025/26 to deliver the national imperatives in respect to RTT, However the Trust have developed ambitious internal stretch targets to improve the RTT for all patients, which exceed nationally agreed targets to continue to improve patient access and experience as part of the Trust productivity improvement initiatives and the refreshed Trust strategy 2025-28.

**Cancer Standards**

The table below represents the performance against National cancer standards. Please note that the Q4 position is an unvalidated position due to timing of this report:

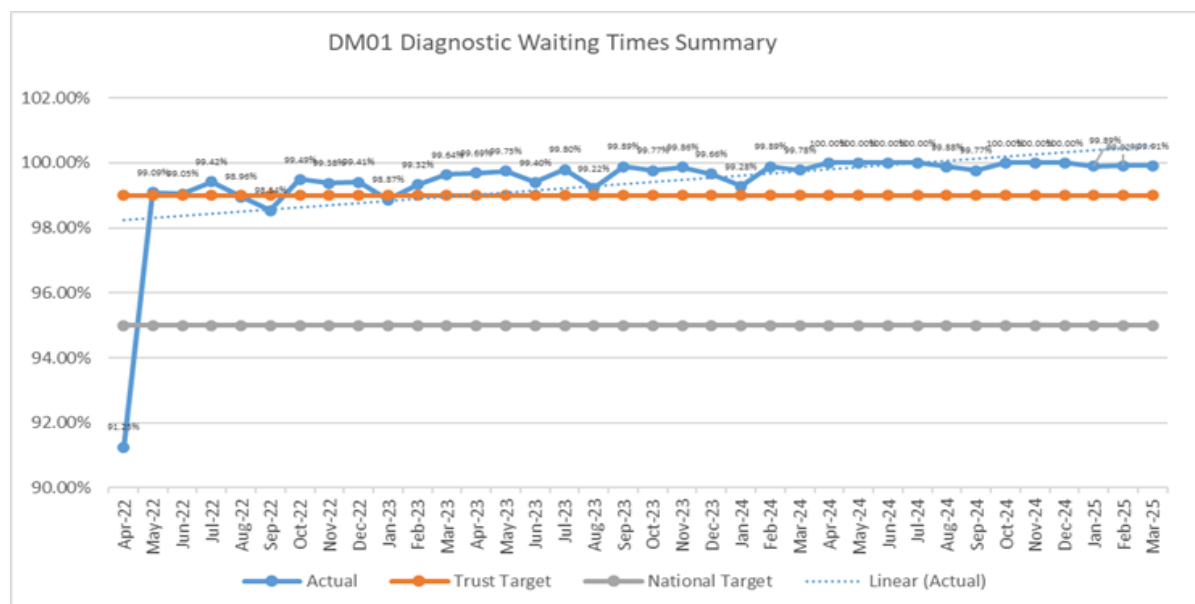
Performance Indicators: Cancer Services 2024/25	Target	Q1	Q2	Q3	Predicted Q4 (Not validated due to March 25 submission date)
% patients receiving subsequent treatment within 31 days (surgery)	96%	100%	100%	100%	100%
% cancer patients treated within 62 days of referral	70%	76.4%	89.4%	88.2%	76.5%
Faster Diagnostic standard (FDS)	77%	79%	83.6%	82.6%	80.1%

The Cancer standards have been consistently achieved through 2024/25. This denotes exemplary performance in the context of a decline nationally in the ability to deliver these challenging performance standards.

The ROH has continued to lead on an international level for Sarcoma treatment and research, hosting the national BOOM (Birmingham Orthopaedic Oncology Meeting) which was attended by representatives from around the globe. There were also two peer reviews undertaken of this service during 2024/25, both noting areas of excellent practice with no significant issues identified.

**Diagnostic Performance**

2024/25 saw the consistent achievement of the diagnostic standards target with the service performing over 99% throughout the year and overachieving the national standard set at 95%. This is demonstrated in the graph below:



**1.6.4 Developments 2025/26**

The Executive and Senior Leadership team have developed a series of key priority projects for 2025/26 agreed by the Trust Board. The Operational Service Improvement Board (SIB) will be re-named the Trust Improvement Group in line with the refreshed Trust strategy 2025-2028. This will continue to ensure clear governance and assurance is provided, whilst driving a continuous improvement culture. The group will continue to oversee the project work to maximise productivity in referral pathways, Day Case maximisation,

Outpatients Transformation, Pre-operative Assessment, Theatres, and the private patient offering at ROH, as well as projects aligned to the Trust's cost improvement programme.

As a result of the Trust theatre improvement group the team have introduced a twice daily huddle to ensure that activity is maximised and capacity is backfilled for short notice cancellations. During Q4 the Trust's theatre productivity improved by 4.68% to 84.04% compared to the December 24 baseline of 79.36%. The team also organised some high intensity theatre lists within Arthroplasty, where the surgeon operates within 2 parallel theatres to deliver a higher number of cases. The team have also introduced a regional block area to improve turnaround and throughput through the small joint's theatres.

The Trust had its Getting It Right First Time (GIRFT) elective hub accreditation annual review and received positive feedback on progress against the Trust's action plan to improve productivity within theatres. The team attended a national event at the Royal College of Surgeons to present on the benefits that accreditation provides to organisations. The operational team are also working on the GIRFT Further Faster principles for outpatients and perform well against the metrics. In addition, a comprehensive outpatient plan in place to deliver improvements to create further capacity for our patients. The Trust continues to focus on reducing the number of missed appointments using a text message reminder system.

An enhanced Joint Care Pathway has been developed to continue to deliver an improved patient experience. The ambition for 2025/26 is to gain support within the system for the development of a 'state of the art' 23-hour Ambulatory Care unit, to continue to improve our patients and staff experience and maximise productivity.

Following the award of Major Revision Centre status in November 2021, the Trust established a multidisciplinary (MDT) infrastructure, as well as data analysis and submission, which is now well established. The strategic intention in 2025/26 is to continue to foster excellent working relationships with other providers in the region and nationally and to continue to develop a strong network in line with other national frameworks such as Major Trauma Networks.

The Trust continues to lead on the system MSK transformation Programme, reporting to the System Elective Hub and upwards to the System Acute Provider Collaborative. This year has seen the successful delivery of a business case following a pilot led by ROH (supported by Keele University) to implement a system wide clinical decision-making tool. This will be implemented across the system in 2025/26. The MSK Programme has also rolled out a system wide digital self-management tool. This is now being used by over 20,000 patients and staff in BSol within primary and secondary care.

The Programme has also delivered several innovative initiatives to raise awareness and support improvements of MSK health across BSol such as health hacks where teams have raised awareness of MSK related health in a school setting, community appointment days and the BSol MSK health bus within the community. The ROH have also led the national initiative 'Go further faster' on behalf of the system to reduce community MSK waiting lists working with partners across the system. The result of this national initiative supported by the Department of health and the Department of Work and Pensions has resulted in the reduction of patients waiting for Physiotherapy services over 18 weeks at ROH from 36 % in December 2024 to 1% in April 2025. The impact in reduction within BSol was a 59% reduction in patients waiting over 18 weeks for community physiotherapy from December 2024 to April 2025. This has attracted national interest and as a result of this achievement members of the team are currently sharing best practice on National learning events. The programme will continue in 2025/26 to develop a workforce model supporting equity of waiting times for this service across BSol supported by a single point of access model.

### 1.6.6 Quality Performance

The Trust worked to deliver a set of quality priorities during 2024/25, as described in last year's Quality Accounts. Three of these have been completed during the year and two will continue to be delivered as part of the work next year:

- Reducing surgical site infection risk rates for knee replacement and spinal surgeries undertaken at ROH from 2024/25 onwards;
- Improve the quality of communication to our patients;
- Develop and implement a health inequalities plan with clear targets and objectives to improve patient access / experience and to meet the needs of our local population;
- Optimisation of patient's health prior to surgery; and
- Introduction of service accreditation across all clinical areas.

The following are our 2025/26 quality priorities which have been set:

- Year 2 - Reducing surgical site infection risk rates for knee replacement and spinal surgeries undertaken at ROH from 2024/25 onwards;
- Art for Health – exploring alternative approaches to supporting patients with chronic pain;
- Minimising the risks and potential impact of medical neglect among children and young people with limited engagement in health services due to existing health-related barriers;

- Reduction in length of time for patients to wait for access to the Spinal Service; and
- Year 2 of the roll out of Service accreditation.

Further detail on quality performance and developments can be found within the 2024/25 Quality Account which is published on the Trust's internet site. Additional detail can also be found within the Annual Governance Statement of this annual report.

## 1.6.7 Financial Performance

The 2024/25 financial year has again been a challenging year for both operational and financial performance within the Trust and Birmingham and Solihull Integrated Care System (BSol ICS), with the Trust reporting a small deficit of £2.123m for the year, which is reflective of an underperformance on elective income during the year.

### Narrative to the Accounts

This section sets out the key features of the trust's financial performance in 2024/25. A full set of accounts is attached including:

- Statement of Comprehensive Income
- Statement of Financial Position
- Statement of Changes in Taxpayers' Equity
- Statement of Cash Flows

### Statement of Comprehensive Income (SOCl)

The Trust's financial position is based on a consolidated financial position of the Trust and its Charity (together 'the Group'). This consolidated financial position is referred to as the Group within the annual accounts and this commentary. The Group delivered a £2.123m deficit for 2024/25 (2022/23: £5.397m deficit) as per the Statement of Comprehensive Income (SOCl). In previous years, a Control Total has been set for the Trust which adjusts the retained deficit for the Group by removing the impact of impairments, donated assets and the Trust's Charity. It is this Control Total that is used by NHS England to assess financial performance. For 2024/25 this is a £1.630m (Trust only) deficit as shown below (2023/24: £4.697m deficit).

### Financial Performance 2021/22-2024/25

£000s	2024/25	2023/24	2022/23	2021/22
Operating Income	150,388	135,707	127,649	115,584
Operating Expenses	(151,339)	(139,687)	(125,288)	(113,783)
<b>Operating Surplus / (Deficit)</b>	<b>(951)</b>	<b>(3,981)</b>	<b>2,361</b>	<b>1,801</b>
Net Finance Costs / Other gains and losses	(1,172)	(1,417)	(920)	(1,418)
<b>Retained deficit for the year (per SOCl)</b>	<b>(2,123)</b>	<b>(5,397)</b>	<b>1,441</b>	<b>383</b>
<b>Control Total Adjustments:</b>				
Reversal of impairments	(4)	346	(1,215)	361
Consolidation of charities	406	263	60	(104)
Donated assets	91	91	82	(218)
<b>'Control Total' Surplus / (Deficit)</b>	<b>(1,630)</b>	<b>(4,697)</b>	<b>368</b>	<b>421</b>

The table above reconciles the surplus position reported in the Group's SOCl to the performance against its Control Total, and shows the Trust delivered a £1.630m deficit in year. The following control total adjustments are made:

- Net Impairments (£0.004m). The Group has been subject to a valuation of its land and buildings during the current financial year and has also made a reversal of a previous impairment as required by accounting policies. As a result, this generated a small net gain and is recognised in the accounts. This is detailed in Note 8;
- Consolidation of Charities (£0.406m). The accounts are provided in Group form. This adjusts to show Trust transactions only; and
- Donated assets income and depreciation (£0.91m)

The bottom of the SOCI also reflects other comprehensive income (and expenditure) that is not classified as Income and Expenditure. This includes an impairment reversal of £0.830m (which relates to the revaluation of buildings and is detailed in Note 8) and a small reduction in the value of non-current assets of £0.015m detailed in Note 19.

### Statement of Financial Position as at 31 March 2025 (SOFP)

The Statement of Financial Position sets out total assets employed by the Group.

- **Non-Current Assets £68.739m (£1.398m increase)** – This relates to an increase in buildings, plant and equipment of £3.982m net of impairments and depreciation (Note 15) offset by a right of use asset charge of £2.521m (Note 18.1).
- **Current Assets £22.275m (£11.323m increase)** – There has been a £10.397m increase in receivables which is mainly due to NHS contractual income that has been agreed but not yet received in cash;
- **Current Liabilities £29.054m (£10.715m increase)** - This relates to an increase in trade payables, due largely to timing differences;
- **Non-Current Liabilities £12.015m (£2.114m reduction)** - This relates mainly to the lease liabilities (Note 28) due beyond 12 months. These non-current lease liabilities will reduce annually in line with the reduction in non-current “right-of-use” assets above; and
- **Total Assets employed** - The overall assets employed by the Group has therefore increased slightly to £49.945m (£45.815m in 23/24).

### Statement of Cash Flows for the year ended 31 March 2025

The Group ended 2024/25 with a cash balance of £3.757m, a small increase of £1.174m on the previous year-end cash balance.

### Analytical Review of 2024/25 Annual Accounts

#### Review of Operating Income

The Group earned income of £150.388m in 2024/25, a rise of £14.682m compared to the previous year (2023/24, £135.707m). This is inclusive of all non-recurrent system reimbursement and provider elective recovery funding received. Of this, £140.636m relates to patient care activities, with the remaining £9.752m generated from other operating income.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust has met this requirement. Other income received in the financial year is used in support of the Trust’s core services of treating orthopaedic patients.

#### Review of Operating Expenses

The Group incurred operating expenses of £151.339m in 2024/25, an increase of £11.652m compared to the previous year (2023/24, £139.687m). Pay costs continue to account for most of the expenditure, with £86.173m or 57% of the total spend (2023/24, £79.223m and 57%).

The increase in expenditure is attributable to the following factors:

- Pay costs increased by £6.951m reflective of national pay agreements;
- Purchase of healthcare from non-NHS bodies increased by £3.073m (this relates predominately to the cost of running theatres); and
- Increase in payroll related provisions of £1.855m.

#### Financial Accounts

The full set of Accounts is included within this report. The accounts have been prepared on a going concern basis and in accordance with International Financial Reporting Standards (IFRS) and the Trust’s accounting policies. Their preparation has been guided by the 2024/25 Department of Health and Social Care Group Accounting Manual (GAM) and the 2024/25 NHS Foundation Trust Annual Reporting Manual (FT ARM).

The Trust's accounting policies are in accordance with directions provided by the Secretary of State for Health and follow International Financial Reporting Standards and GAM to the extent that they are meaningful and appropriate to the NHS.

#### Post Year-End Events

There have been no important events since the end of the financial year affecting the Foundation Trust that influence the information within this Annual Report.

### 1.7 Information on Environmental Matters

The ROH continues to be proud of its 'Green Apple' award status, it has a long 100-year history in providing well maintained grounds & gardens for its staff and service users. The 'Woodlands Site' has a wide variety of trees, plants and shrubs which support the control of greenhouse gases. The Trust continues to maintain its green canopies; through the NHS Forest Programme the Trust was successful in its 2024 application and received over 150 Hawthorn trees which have been planted in the woodland area. The Trust continues to nurture and improve its 'Greenspace', with herb gardens and flower beds which has benefits for Health & Wellbeing and leads to improved air quality, noise reduction and supports Biodiversity.

The Trust Board approved its 'ROH Green Plan' in 2021, the plan is regularly reviewed. The plan sets out the Trust's strategy for playing its part in working towards delivering our contribution to a 'Net Zero NHS'. The ROH has established workstreams to examine and question its approach to environmental factors, carbon reduction and achieving a more ecological sustainable future. We are working in partnership with organisations to promote initiatives to reduce air pollution, such as free bus travel for one month, no idle zones at our entrances, flexible/hybrid working and cycle to work schemes. We continue to invest in smart technology to reduce our carbon footprint. Progress against the Green Plan is monitored by the Trust's 'Green Board' that meets quarterly, and reports through to the Finance and Performance Committee, and the Trust is also represented at the BSol ICS Sustainability Programme Board, which meets monthly, which monitors progress across the healthcare system.

The Trust recognises technological developments in 'alternative energy'; these will play a big part in adapting our environments to meet the future needs of the service. The Trust has invested in 'Solar Power' on its hospital roofs between 2022 to 2024, the return on investment is less than ten years and helps the Trust work towards its sustainable targets. We are currently developing a sub metering network on the site which will enable us to monitor energy usage at source. Sustainable development is always considered in our refurbishment programmes; we continue to install energy efficient lighting in our wards and departments, together with other energy efficient devices. Energy efficient boilers continue to be installed in various locations which helps further reduce our energy consumption.

The Trust work with local transport providers to provide discounted travel for our staff. In conjunction with our local transport partners, we continue to develop our 'Health Travel Strategy' with a focus on reducing single occupancy car journeys and the impact of transportation within our Procurement Supply Chain. We have invested in twelve electric charging points for our staff, visitors, and patients together with electric vehicles for the transportation of blood samples and medical notes between our off-site clinical facilities and other local healthcare providers.

The Trust has reviewed the use of its anaesthetic gases and has removed the piped nitrous oxide gas from the site; Desflurane, an anaesthetic gas product, known to be associated with high carbon emissions, has also been removed from use. We continue to make changes to our non-clinical waste streams reducing the amount of waste going to landfill, we are trialling reusable sharps containers and developing our recycling waste streams.

### 1.8 Statement on the Modern Slavery Act 2015

The ROH recognises it has a responsibility to take a robust approach to slavery and human trafficking and is absolutely committed to preventing slavery and human trafficking in its activities.

The Trust has comprehensive safeguarding policies that highlight the need to protect vulnerable individuals. The policies are:

- Safeguarding Adults and Families at Risk; and
- Safeguarding Children, Young People and Families

We also refer to the Birmingham Safeguarding Adults Board and Birmingham Safeguarding Children's Board policies and procedures.

Both safeguarding leads attend regular external training sessions to keep up to date with the latest information and support available.

As part of the Trust Statutory and Mandatory training, all staff members are required to attend a safeguarding session to give a general awareness on modern slavery. There is also information and guidance on where to go for help if they are concerned about vulnerable individuals with whom they come into contact.

## 1.9 Anti-bribery

The Trust has adopted the model policy around conflicts of interest, which includes references to the Bribery Act 2010. The policy remained live for the 2024/25 year. It provides clear guidance on the acceptability of accepting gifts, hospitality and sponsorship and the processes needing to be followed when offered. The Trust has the benefit of the services of a Counter Fraud Advisory Service provided through the Internal Audit Contract. The Trust has developed a public statement for the Trust on anti-fraud and bribery.

### 1.10 The Knowledge Hub

#### 1.10.1 Education and Training Summary

When it comes to Education and Training, the ROH is a highly regarded teaching hospital. As an Education Provider for NHS England Education, the Trust provides specialist orthopaedic teaching and education for several local universities and Higher Education institutes. Through the annual Education Funding Agreement and financial schedule with NHS England Education, the Trust's educational activity generated £3.26m in financial income, up from £2.81m in 2023/24. The income received from the EFA, supports the Trust in mitigating the impact student teaching may have on activity levels, whilst allowing the Trust to provide an exceptional education infrastructure to enable the provision and delivery of the training, education activities and resources.

#### 1.10.2 Education and Training – Key Highlights

##### 1.10.2.1 Medical Education

##### Undergraduate Academy Medical Education

The Trust continues its partnership with the **University of Birmingham (UoB) and Aston University Medical School** with 450 fourth year UoB Medical Students and 132 Aston Uni Med School completing a two-week musculoskeletal placement on site during the academic year. The Trust have delivered the inaugural 3-week Student Selected Experience placement for 5 UoB year 4 medical students. The Trust continues to deliver the 1-week Peri-operative medicine placement for Aston Uni Med Students

##### Post Graduate Doctors training:

**Post Graduate GP trainee placements and teaching:** During their rotational placements from the West Midlands Deanery, GP trainees support the Trust in providing high standards of patient care. This year, the GP allocation to the organisation has been lower than that of previous years, meaning a maximum of 2 GP trainees per rotation. The ROH have been assured by NHSEWM the number of GP trainees will increase to 5 trainees allocated per 4-month rotation.

**Specialty, Associate Specialist, and Specialist (SAS) Doctors development days:** The Director of Medical Education has initiated Specialty doctors' development half days for any SAS doctor. Two half days have been completed containing information from key stakeholders including: Appraisal and revalidation; Library Services at the ROH; Clinical Governance and patient safety; Health and Wellbeing/managing stress; NHS pension; Specialty, Associate Specialist, and Specialist (SAS) doctors study leave funding.

**Grand Rounds:** The Director of Medical Education has established a new Bimonthly initiative named 'Grand Rounds. This initiative is a multi-healthcare professional forum to focus on development, innovation, and community.

**Birmingham Orthopaedic Teaching Programme (BOTP):** The Trust continues to host one of the largest and most successful orthopaedic training programmes in the UK, comprising 40 trainees rotating through twelve hospitals across the West Midlands. Twelve registrars work on rotation with the Trust developing their skills whilst delivering great patient experience and outcomes.

**Fellowship of the Royal Colleges of Surgeons Revision Course:** The Medical Education team hosted a Fellowship of the Royal Colleges of Surgeons Trauma & Orthopaedic (FRCST&O) Revision course designed to prepare senior registrars for their FRCS exams, led by Mr Khalid Baloch, Director of Medical Education, and Consultant Orthopaedic Surgeon.

**Birmingham Orthopaedic Network:**

The Birmingham Orthopaedic Network (<https://sites.google.com/view/birminghamorthopaedicnetwork/home>) continues to grow from strength to strength since its launch. The BON is active on social media (twitter @borthonet), and through connections with colleagues and regional and national level stakeholders, has been shared and presented widely. BON is not restricted to just medical staff, and we continue to engage and develop the platform to include colleagues in other specialties, including nursing and therapy services.

**1.10.2.2 Library Services**

2024 saw changes at the ROH Library with the appointment of a new Librarian Team Leader and Assistant librarian. Continued implementation of the Library strategy saw the introduction of new library branding, a library charter, and a growth in literature searches (85) and article requests (1171) when compared with 2023. Our targeted improvement plan increased Library compliance with NHS England's Quality Improvement Outcomes Framework (QIOF) from 8/16 essential indicators in May 2024 to 12/16 by year-end, demonstrating successful progress towards our 2027 review. In the year ahead, we aim to expand on existing achievements, continue implementation of the library strategy and strengthen our relationships with staff and students across the Trust. For a copy of the Library Strategy or to engage with our services please email [roh.library@nhs.net](mailto:roh.library@nhs.net)

**1.10.2.3 Non-medical Education and Training**

The Trust continues to provide educational placements for up to 60 non-medical students, from partner universities at any one time. This year it has received students from the new Nursing Degree Programme at University College Birmingham and is in discussion with Aston University regarding placement support for their nursing degree which commenced in September 2024, and Newman University also.

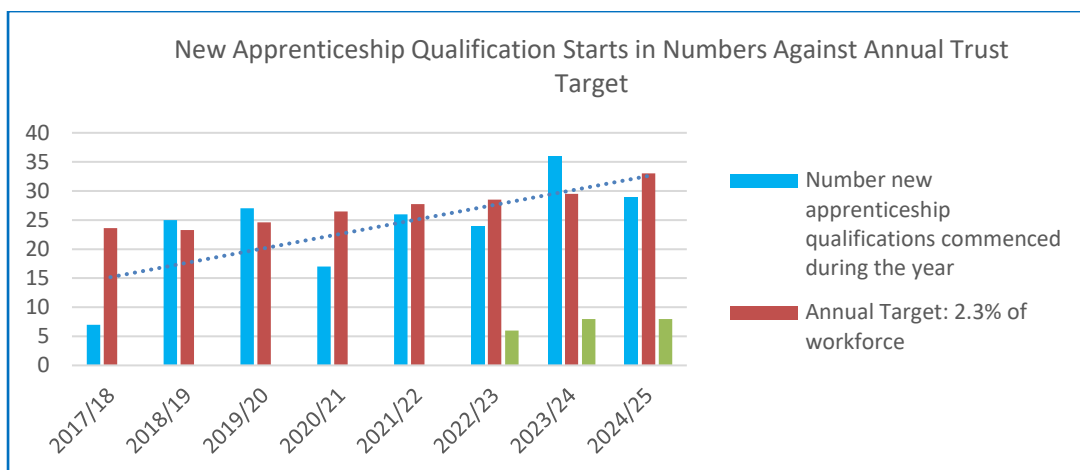
The Trust supports a range of speciality undergraduate placements, including:

- ✓ adult nursing degree
- ✓ physiotherapy
- ✓ radiography
- ✓ occupational therapists
- ✓ operating department practitioners
- ✓ pharmacy

The Trust is actively engaged with supporting the implementation of the education reforms across the Birmingham and Solihull Integrated Care System. The Trust works closely with other local trusts, universities, and Higher Education Institutions as part of the BSoI regions Education Collaborative (EC), to ensure university places are fully utilised, the regional capacity for providing placements is enhanced, and that a future workforce supply of registered professionals is continually produced.

**1.10.2.4 Personal and Professional Development of our workforce**

**Apprenticeships:** The Apprenticeship Levy came into force in April 2017. This levy amounts to 0.5% of the Trust pay bill, at £300,000.00 annually, which the Trust can invest in the delivery of apprenticeship standards and career frameworks within the organisation. The Trust developed a robust Apprenticeship strategy which it continues to perform well against. A summary of our Apprenticeship targets and achievements are detailed in the table below.



By the end of the financial year 2024/25 there have been **29 apprenticeship qualifications commence** (2.03% as a percentage of workforce headcount). This has missed our national target of 33 (Based on a national target of 2.3% of workforce). Our target for 2025/26 is 34, and there are currently 30 qualifications that are in discussion.

**Apprenticeship Levy Utilisation:** On 31st March 2025, the Trust has paid a total of £1,914,016.99 towards the Apprenticeship Levy since its introduction in April 2017. Of this total amount, 59.23% has been accessed by training providers to fund apprenticeship qualifications in the Trust (positive increase from 51.81% in March '24), 29.38.48% remains available (positive decrease from 35.39% in March '24) and 11.39% has expired (an improvement from 13.43% in March '24). The Trust has not expired any funds since April 2024 (funds not used after 48 months). (Red section in the graph)

Since 2023, the Trust has gifted levy funding to support smaller charitable organisations that do not pay into a levy fund. In total, on 31st March 2025, the trust has gifted £35,166.00, which is 1.84% of the total trust levy post. (Yellow section in graph)

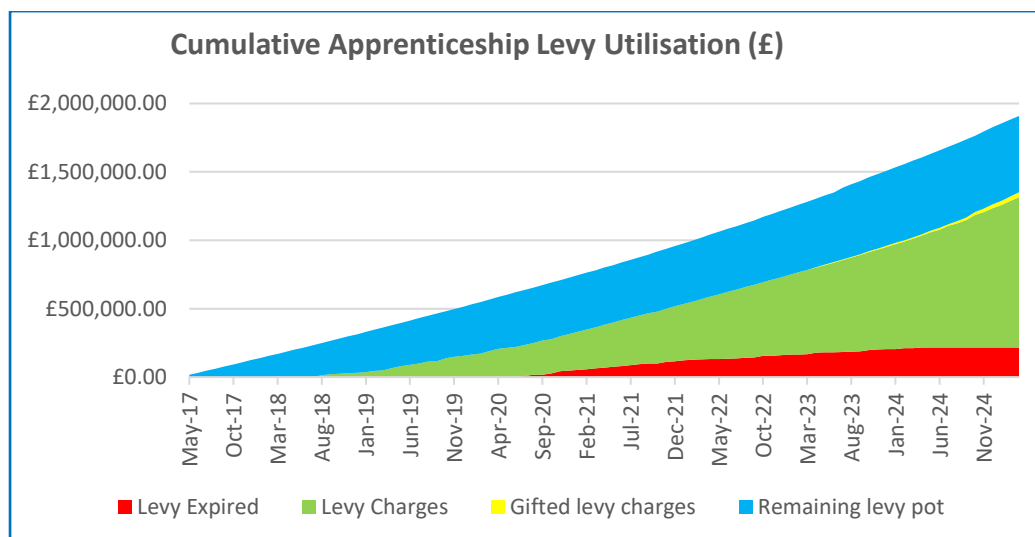
The Trust is currently supporting 13 organisations, with 19 of their employees completing apprenticeships funded by the ROH levy funding. This is not only supporting smaller charitable organisations develop the skills and qualifications of their individuals, it also make more effective utilisation of our levy to ensure we are not expiring any additional funds in the future.

The graph below shows the percentage utilisation of the ROH Apprenticeship Levy funds on 31<sup>st</sup> March 2025.

To improve the utilisation of the levy, the Trust needs to continue reviewing its workforce models to create more apprenticeship opportunities, to increase the monthly levy spend, and reducing the funds within the pot and in turn will reduce the amount of funds expiring.

We are now at the point of developing our next Apprenticeship strategy to support the delivery of the ROH Long Term Workforce Plan. The Trust continues its work with the BSol Apprenticeship Federation, and the ROH lead on the 'career development on a page' frameworks, developing a web platform that enables individuals to review the career web of career development stages, and the opportunities and requirements to move between each. This is available from the following link:

[Home page - Career PathFinder](#)



**Work Experience:** In October 2024 we delivered a four-day Work Experience programme for school students in a seminar format with input from our multi professional teams. The students were very appreciative of the programme and gained insights to the wide range of job roles in the NHS and working in Orthopaedics. We are also accommodating other work experience placements where support is available in the Trust, not at the levels previously. These are now restricted to those over 18. We are also supporting numerous careers and apprenticeship events across BSol and looking at what can be achieved as a system.

**T-Levels:** In 2024 work has progressed with T-Level students accessing placement support across the system. Whilst ROH has been unable to provide placements for this programme we have provided Core Mandatory Training opportunities to support students with their Core Skills Training Framework compliance in readiness for placements across other BSol Trusts, where locally they will receive top-up Induction/welcome events. In future years we will review whether we can widen our support with T-Levels for Health Care Support / Nursing careers.

**Investment in Learning:** The Investment in Learning charitable fund was set up in December 2013, with the key aim to support the personal and professional development of staff in Band 1-4 roles and higher banded non-clinical staff. Charitable funding was initially allocated to support apprenticeship qualifications, Customer care training, developing technical skills and professional qualifications for career progression. The Investment in Learning charitable fund allocation continues to support the professional and personal development of staff, who continue to be extremely grateful for the support, which has enabled them to progress in their careers and achieve further development opportunities.

**Activity group Personal development courses:** The Trust has also commissioned the Activity Group to deliver a series of personal and professional development workshops that support the achievement of the Trust's Objectives and support staff in their personal development. These programmes have generated great interest, and we have experienced high attendance rates. The courses have also evaluated very positively.

**Personal and Professional Development:** The ROH is committed to support the personal and professional development of our employees and seeks to develop our own internal talent. To support staff development the Trust provides a range of programmes and resources to support career development:

- Management Skills Programme – A 12-month programme, linked to a Level 3 Team Leader / Supervisor Qualification.
- Nursing and AHP Development Programme – A 12-month programme supporting the progression of Band 6 Nursing and AHP staff.
- Preceptorship Programme – A 12-month programme supporting newly qualified and international nurses joining the organisation.
- Personal Development Courses – a range of half a day, and full day courses to support your personal and professional development.
- Access to the NHS Leadership Academy resources. <https://www.leadershipacademy.nhs.uk/> - access to the full range of leadership development programmes.

**Training Activity:** The table below details the number of delegates who have attended courses in the last 12 months, against total capacity for training. The table shows that the Trust delivered over 300 courses and has a 73% utilisation rate on the courses available.

Title of in person training course	Count of delegates	No of courses delivered	Max Attendance per course	Total Delegates places	% Utilisation of course places
303 100 Day Briefings for Managers	51	6	N/A	51	100%
303 Me as Manager Briefings	140	13	N/A	140	100%
303 Core Mandatory Training	488	12	50	600	81%
303 Delegation & Engagement Skills	13	1	12	12	108%
303 Developing Self Awareness	9	1	12	12	75%
303 Effective Minute Taking	7	1	12	12	58%
303 Enhanced MCA & Dols Training	49	8	12	96	51%
303 Hospital Life Support (Adult)	640	99	12	1188	54%
303 Immediate Life Support & Recert (ILS)	158	35	6	210	75%
303 Introduction to Leadership	8	1	12	12	67%
303 Mental Health Training	23	1	22	22	105%
303 Paediatric Immediate Life Support & Recert (PILS)	22	5	6	30	73%
303 Patient Handling	485	73	8	584	83%
303 Patient Safety Update Day - Registered Nurses	89	9	12	108	82%
303 PPE Training	23	5	10	50	46%
303 Safeguarding Adults & Children Level 3	247	13	20	260	95%
303 SAS Doctors Development Day	12	2	6	12	100%
Oliver McGowan Training - Tier 1 (non-clinical)	43	System courses	system courses	43	100%
Oliver McGowan Training - Tier 2 (Clinical)	149	System courses	system courses	149	100%
303 Spinal Observation Training	45	9	8	72	63%
303 Working with Assertiveness Training	10	1	12	12	83%
303 WRAP (Prevent) Training	72	10	12	120	60%
<b>Grand Total</b>	<b>2783</b>	<b>305</b>	<b>244</b>	<b>3795</b>	<b>73%</b>

The table above shows the number of staff that have completed e-learning in the relevant modules. This shows that over 8000 modules have been completed online in the last 12 months.

## 1.11 Auditor's Opinion

Audit opinion is supplied by Deloitte LLP and is included within the 'Financial Statements' section of the annual accounts.

## 1.12 Going Concern Statement

International Accounting Standards (IAS1) require the Directors to assess, as part of the account's preparation process, the Foundation Trust's ability to continue as a going concern.

The guidance in the NHS Foundation Trust Annual Reporting Manual (FT ARM) continues to state that '*the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern*', and furthermore '*an NHS foundation trust's assessment of whether the going concern basis is appropriate for its accounts should therefore only be based on whether it is anticipated that the services it provides will continue to be provided with the same assets in the public sector. This is expected to be the case for NHS foundation trusts unless exceptional circumstances indicate otherwise; these should be discussed with NHS England*'.

In addition, in 2020/21, there was a practice note issued by the Public Audit Forum to audit firms updating its guidance to align more with the above – previously there was a mismatch between the testing required by external audit (more akin to a private sector going concern assessment, which would include extensive assurance on areas such as cash flow, funding and contractual arrangements, and governance considerations) and that required by the Directors under the FT ARM.

The Trust continues to be a specialist provider of orthopaedic services, treating patients not only from the local area for common procedures such as primary hip and knee surgery, but also from across the UK for some of its specialist services, such as complex spinal deformity (e.g., spinal scoliosis), orthopaedic oncology, bone infection procedures and complex revision surgery. There remain substantial waiting lists across the country for orthopaedic services post Covid, which suggests a continuing need in the UK population that is required to be met.

Therefore, this need has allowed the Directors to assess that, on the basis of their enquiries, there is still continuing demand for orthopaedic services, and that there is still a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

As such the financial statements, as provided in detail in later sections of the Annual Report, have been prepared on a Going Concern basis. The assumptions within the financial statements have been fully challenged through Audit Committee and Trust Board.

**Approved by the Board of Directors on 25 June 2025**

A handwritten signature in black ink, appearing to read 'Matthew Hartland'.

**Matthew Hartland**  
**Chief Executive**  
**25 June 2025**

## ACCOUNTABILITY REPORT

### Section 1: Directors' Report

#### 1.0 Directors holding office during 2024/25



**Timothy Pile – Chair (January 2021 – Present). Appointed in January 2021, with the first term of office in this role concluded in January 2024. Further term of office approved by the Council of Governors which concluded on 31 March 2025 and was subsequently extended up to 1 September 2025.**

Tim has worked in a number of different industries such as banking, retail, marketing, consumer goods, manufacturing, as well as in the charity and public sectors – for organisations big and small.

Tim was the Chair of the Greater Birmingham and Solihull LEP until the end of 2021 and was a Non-Executive Director of Marshalls Plc. He is a member of the Council of Aston University.

Tim was Chief Executive and Executive Chairman of Cogent Elliott. Prior to this, Tim was Chief Executive of Sainsbury's Bank and a member of Sainsbury's Operating Board.

Before Sainsbury's, Tim led the Retail Function of the Alliance and Leicester Group as Marketing, Strategy and Sales Director and served at Lloyds TSB as Marketing Director.

He has held a number of non-executive roles including serving on the board (and as past president) of the Greater Birmingham Chambers of Commerce, being a trustee of the Library of Birmingham, a governor at Bromsgrove School, Honorary Senior Fellow at Birmingham Business School and was on the Board of Cancer Research UK.

Tim, on approval by the Council of Governors, took up post as Chair, with an initial term of office which concluded on 1 January 2024. A further term of office was agreed by the Council of Governors which concluded on 31 March 2025, following which a short extension until 1 September 2025 was agreed while the Chair post was recruited into. Prior to his time as Chair, Tim was the Trust's Vice Chair, Senior Independent Director and Chair of the Finance & Performance Committee.



### **Joanne (Jo) Williams, Chief Executive Officer (substantive)**

In June 2017, Jo joined the Trust as Chief Operating Officer, on secondment from University Hospitals Birmingham NHSFT, where she was Deputy Chief Operating Officer for three years and Deputy Director of Partnerships for the STP (Sustainability and Transformation Partnership).

Jo gained significant operational experience working in a number of acute hospitals delivering and leading service transformation projects. As well as 14 years in operational management, she also worked in procurement both in the NHS and was a capital buyer for the private healthcare sector.

Jo was appointed as substantive Chief Executive of the ROH in 2019. Jo was seconded to Shrewsbury and Telford NHS Trust in September 2024, an arrangement which is due to be reviewed in the Autumn of 2025.



### **Matthew Hartland, Chief Executive Officer (interim)**

Matthew joined the Trust on secondment from the Black Country Integrated Care Board in October 2024.

Matthew has over 30 years of experience in the health sector, particularly in NHS finance and executive leadership roles. His positions have included Chief Executive of Dudley Integrated Health & Care Trust, Chief Operating Officer of the Integrated Care Board (ICB) and Deputy CEO of the Black Country Clinical Commissioning Group.



### **Simone Jordan – Non-Executive Director, Vice Chair and Senior Independent Director (Term of Appointment as an Associate Non-Executive: 1 July 2017. Appointed as a substantive Non-Executive Director from October 2020, Vice Chair from April 2021 and Senior Independent Director from September 2022). Further term of office approved which concludes on 30 September 2026.**

Simone is an experienced Executive, working at Board level for 20 years, as a Chief Executive, Executive and Non-Executive Director. Her professional background is in Workforce, Human Resources and Organisational Development. She also has significant leadership and personal development expertise. Her UK experience includes service and hospitality sectors, manufacturing, health, higher education and other public sector organisations. Simone's roles have included Managing Director of Health Education East Midlands, Director of Workforce for East Midlands Strategic Health Authority and Deputy Chief Executive and Chief Operating Officer for the NHS Institute for Innovation & Improvement.

Simone holds an honours degree in History and has an MBA.

Simone has led numerous major cultural and organisation change programmes across multiple organisations working in complex political environments.

Simone is an experienced leader, qualified coach, mentor and facilitator with a detailed understanding of organisation dynamics and functioning, governance and accountability frameworks.

Simone is Chair of the Staff Experience & Organisational Development Committee and the Nominations and Remuneration Committee.



**Ayodele Ajose – Non-Executive Director (Term of Appointment as an Associate Non-Executive Director: 1 November 2019. Appointed as a substantive Non-Executive Director from 1 April 2021 – March 2024. Further term of office approved which concludes on 31 March 2027).**

Ayodele is a Barrister and experienced commercial lawyer, working at Board level for over 15 years as General Counsel and Legal Adviser within both the private and public sectors. In addition to commercial law, her legal background covers intellectual property, licensing, R&D, commercial software and systems integration. Her professional experience extends across a range of industry sectors as General Counsel to Forensic Science Service, legal consultant to global pharmaceutical companies Hospira Inc and Pfizer Ltd and more recently Head of IP and International for Britvic plc. Ayodele has advised CEOs and Executive Teams on corporate governance, international expansion projects and product launches within the USA, EMEA and China and advised senior executives on the handling of high-profile criminal cases involving miscarriages of justice. Ayodele has directed and led high value public sector procurement frameworks and has advised on major corporate restructuring projects.

In addition to her degree in law, Ayodele has a diploma in Marketing and an MBA.

Ayodele is currently a legal consultant to the international law firm Addleshaw Goddard LLP advising its corporate clients on all aspects of commercial law. She is also Senior Commercial Legal Consultant for Oodle Car Finance.

Ayodele is the Trust's wellbeing guardian and Chair of Charitable Funds Committee.



**Gianjeet Hunjan - Non-Executive Director (Term of Appointment: First term of Appointment ended on 30 September 2023. Further term of office approved, concluding on 30 September 2026)**

Gianjeet was appointed as a Non-Executive Director at the Royal Orthopaedic Hospital NHS Foundation Trust on 1 October 2020 and is Chair of the Audit Committee. Gianjeet is also the Non-Executive lead for Freedom to Speak Up.

Gianjeet is a qualified accountant with extensive experience in the NHS and Education sector. She started her career as a Regional Finance Trainee in the West Midlands and has worked at director level in a variety of health care finance roles within acute services, mental health, forensic sciences and primary care, principally in the West Midlands and North West regions. She has worked at Board level in both Executive and Non-Executive roles. Her interest in education, learning and training extended into Education and supporting businesses through her work with Business Links and the West Midlands Manufacturing Advisory Service.

In addition to her degree in Business Studies and accounting qualification, Gianjeet has a Master of Arts in Finance and Accounting from Leeds Metropolitan University.

Gianjeet is a Governor for Oldbury Academy and Ferndale Primary School. She also serves as a Non-Executive Director for the Black Country Integrated Care Board.

Gianjeet is currently participating in the NHS England Aspiring Chair's Programme.



**Les Williams - Non-Executive Director (Term of Appointment: First term of Appointment until 31 March 2024. Further term of office approved which concludes on 31 March 2027)**

Les was born in Quinton, Birmingham and now lives in Cradley Heath. He graduated with honours in English from the University of Leicester in 1977, and began working in NHS management, a career that lasted for thirty-nine years until his retirement in 2016.

Les's career included working in operational management and then as an Executive Director in contracting, information, planning, delivery and strategy at several of the major hospitals in Birmingham. After several years on the Board at Dudley Group of Hospitals, Les became Programme Director for Right Care Right Here, a service transformation programme in Sandwell and West Birmingham, which developed a range of community-based services and facilities as an alternative to hospital-based care. After working at the Black Country PCT Cluster during the 2012 re-organisation, Les became Director of Operations and Delivery for the NHS England Area Team for Birmingham, Solihull and the Black Country. His final role in the NHS was as Director of Performance and Delivery for Birmingham Cross City CCG, commissioning services for three quarters of the population of Birmingham.

Alongside his work in the NHS, Les was a Governor for eleven years at Halesowen College of Further Education, and was Chair for the last five of these, until 2016. On his retirement, Les undertook family care and developed a keen interest in the local history of Birmingham and its prominent citizens, whether native or adopted, which led to the publication of his first book in 2021.

Les offers his experience of strategy, performance, service re-design and public engagement to help the Trust meet the challenges of continuing to deliver exceptional quality of care in innovative ways. He is passionate about ensuring performance is used to create better outcomes for patients in a supportive environment for staff, governors and volunteers.

Les became Chair of the Finance and Performance Committee in January 2024



### **Ian Reckless Non-Executive Director (Term of Appointment: First term of Appointment until 31 October 2025)**

Ian was appointed as Non-Executive Director at The Royal Orthopaedic Hospital on 1 November 2022.

Alongside his Non-Executive Director role, Ian is also the Medical Director at Milton Keynes University Hospital. He qualified from St George's Hospital Medical School, London and undertook postgraduate training in the Oxford region. He worked as Special Adviser to the Healthcare Commission in 2004 and was Special Assistant to the Chief Medical Officer in 2005-06.

Ian was appointed Consultant Physician and Senior NIHR Research Fellow at Oxford University Hospitals in 2007. He also held the roles of Associate Medical Director (Quality) and Clinical Director, Neurosciences. Ian has a good understanding of system working having been a member of the Governing Body of a Clinical Commissioning Group (CCG) for several years and is currently leading work with partner organisations on behalf of MKUH.

Ian continues to undertake clinical work in Acute Medicine. He remains an Honorary Consultant Stroke Physician / Senior Clinical Lecturer at the John Radcliffe Hospital.

Ian has a particular interest in postgraduate education, having previously served as Training Programme Director, and has authored books on general medicine, and the interface between medicine and the law.

Ian was appointed as a Deputy Chief Executive of Milton Keynes University Hospital in 2020, with a particular focus on working with partners across Milton Keynes and the wider system.

Ian became Chair of the Quality & Safety Committee in October 2023.

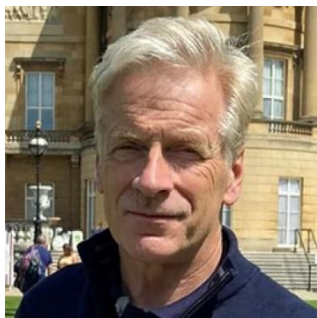


### **Jenny Belza Non-Executive Director (Term of Appointment: First term of Appointment until 31 January 2027.)**

A registered nurse with over 40 years' experience working in the NHS, Jenny undertook her general nurse training in South Wales and then specialised in neurosurgery and has worked in acute hospitals in Cardiff, Cambridge and Leicester.

She has held several senior positions as a NHS manager within hospitals, health authorities and Primary Care Trusts (PCTs). Jenny worked for 11 years in Birmingham in senior commissioning roles. Her most recent full-time position was as a Chief Nurse in one of the Birmingham Clinical Commissioning Groups (CCGs). She has extensive experience of working at Board level including as a Non-Executive Director and Vice Chair at Birmingham Community Healthcare NHS Trust and is currently a governor at University College Birmingham.

Jenny is passionate about ensuring patients receive safe, effective care of the highest quality, addressing health inequalities and supporting the development of a compassionate and inclusive workforce.



**Simon Page Non-Executive Director (Term of Appointment: First term of Appointment until 31 January 2027.)**

Simon Page is an experienced Non Executive Director and he was Deputy Chair at South Warwickshire University Foundation Trust until Spring 2025. He has a career of over 30 years, with wide ranging leadership experience in the private sector as Chairman, Managing Director and Director. Simon's career, prior to his NHS Non Executive Director roles, centred around retailing and manufacturing businesses operating within the consumer and building products markets.

He has a strong background in business transformation, marketing, sales and commercial leadership, working for some well-known blue-chip brands, in both the prestige branded and mass-market arenas; these include Aga, Fired Earth, Villeroy & Boch and Rangemaster. This has given him a clear insight into working for complex international organisations, change management, strategy development and delivery, and of the importance of delivering success with and through others, especially in periods of change.



**Jan Teo, Non Executive Director (Term of Appointment: First term of Appointment until 31 March 2027)**

Jan is a history graduate from the University of Cambridge, and a former chief operating officer, chief executive, managing director and chair with over 30 years leadership experience in a wide variety of roles primarily in financial and motoring services companies such as Deutsche Bank, Barclays, Legal and General, RAC, and Lex Transfleet.

Jan has experience in people leadership, transformation and growth, with an absolute focus on doing the right things whilst managing business sustainability.

Jan has an interest in the provision of wider access to and participation in arts organisations and she has served as a trustee director for Birmingham Museums Trust, Elmhurst Ballet School, The Birmingham Repertory Theatre and Birmingham Royal Ballet where she was later asked to become Chief Executive.

She is currently a member of the Board at Birmingham Community Healthcare NHS Foundation Trust, and recognises the long term challenges in the wider NHS. She joins the Board of The Royal Orthopaedic Hospital NHS Foundation Trust being particularly driven by a focus on equity in health outcomes for all patients and by valuing all NHS colleagues to best use their experience and resources to work collaboratively to do so.



### **Mr Matthew Revell – Executive Medical Director**

Matthew was appointed as Medical Director for the Royal Orthopaedic Hospital in February 2019. He is a Consultant Orthopaedic Surgeon with an interest in hip replacements and revisions, although does not currently work clinically.

Matthew qualified in medicine from Guys Hospital and worked as a Junior Doctor at St Thomas's and in the South East of England. He undertook higher surgical training in the West Midlands and was a Cavendish Hip Fellow in Sheffield.

Since being a consultant, Matthew has maintained an interest in research, medical education, clinical outcomes and medical leadership. He obtained an MBA from Warwick Business School and is a Founding Fellow of the Faculty of Medical Leadership and Management.

Matthew has held a number of management and leadership roles, including Clinical Director for outcomes and effectiveness, Chief Clinical Information Officer and Associate Medical Director for patient support services. He is currently the Caldicott Guardian and the Responsible Officer for the Trust.



### **Marie Peplow – Executive Chief Operating Officer**

Marie Peplow was appointed as Chief Operating Officer in September 2019. She has a keen focus on transforming services whilst keeping the highest quality patient care at the heart of everything she does. Marie started her NHS career over 25 years ago as a Radiographer in Birmingham. Having developed her clinical and academic career in a range of acute Hospital settings in Leicestershire, she then moved into various leadership roles managing Radiology services across Birmingham and Solihull and gained a Masters in Organisational Development. Marie has an impressive track record for achieving national performance targets and driving excellence. Marie started working at ROH in April 2018 as the Deputy Chief Operating Officer (COO), and quickly 'fell in the love with the place.' In her role as Deputy COO Marie drove forward improvement projects such as redeveloping the Pre-operative assessment Centre (POAC) pathway, Theatre expansion, & Improving referral to treatment times (RTT). As the Executive Chief Operating Officer, Marie pledges to deliver a number of key objectives as part of her role, as well as maintaining her passion for keeping patients & staff at the heart of everything she does is the most prominent. Marie works closely with our partners to deliver safe and efficient care, most notably through the elective recovery work.



### **Steve Washbourne – Executive Chief Finance Officer**

Steve joined the Trust on secondment from University Hospitals Birmingham NHSFT (UHB) in October 2017, where he was the trust lead for strategy and planning, before being appointed as Chief Finance Officer in July 2023.

Steve was an NHS National Financial Management Trainee, qualifying as an accountant in 2000. Since then, he has gained significant financial management experience working in a number of acute hospitals, as well as a 10-year spell in commissioning specialised services, becoming Regional Head of Specialised Commissioning for the West Midlands in 2013, before re-joining UHB in 2014.

Steve also leads on Procurement, Estates, and Digital, Data and Technology, and is the Trust's Senior Information Risk Officer (SIRO), and Accountable Emergency Officer (AEO).

Steve is a Governor and Trustee at University of Birmingham School, and is the Independent Member on the Audit Committee of Aston University.

Steve grew up and went to school in Northfield, and still lives locally.



### **Simon Grainger-Lloyd – Executive Director of Governance**

Simon's first interest in the NHS started when he undertook a summer job as a housekeeper at Birmingham Women's Hospital between his university terms.

He was appointed in August 2015, following a number of years as Trust Secretary of a large acute provider trust and Board Secretary of the Forensic Science Service prior to this. He has an Honours degree in Biology and has extensive experience of project and programme management, risk management and Board support.

Simon is the ROH's Data Protection Officer. His other portfolio responsibilities include clinical governance, risk management, health & safety, claims & litigation, Freedom to Speak Up, Freedom of Information and governor & membership engagement and development.



### **Sharon Malhi – Executive Chief People Officer**

Sharon Malhi joined the Trust in April 2019 and has worked as a Senior HR Professional for over 15 years. Sharon is an Alumni of the NHS HR Graduate Management Training Scheme and gained her membership of the CIPD in 2008 following successful completion of her Post Graduate Diploma and went on to complete her MA in Human Resources in 2015. Her experience includes service within the public, private and voluntary sectors where she has led on Organisational Development, Learning and Development, Human Resources and Business Development initiatives and she is also a qualified coach, mentor and incident debriefer. She is a Trustee for Victoria Academies Trust and is Joint Senior Responsible Officer for the Leadership and Inclusion workstream across the Birmingham and Solihull Integrated Care System. Sharon was born in Bradford, grew up in Leeds and moved to the West Midlands in 2006.

Following a period as the Acting Associate Director of Workforce & OD, Sharon was successful in being appointed to the role of Chief People Officer.



### **Nikki Brockie – Executive Chief Nurse**

Nikki joined the Trust in May 2021 as the Deputy Chief Nurse, moving from University Hospitals Plymouth NHS Trust.

Nikki has over 27 years' worth of experience in nursing, clinical and operational leadership and management. She has held senior positions across the UK as a Matron in both Critical Care and Medicine, as a Service Lead in Radiology at Heartlands Hospital, as a General Manager in Cardiac & Respiratory Services in Gloucester and latterly as a Health Education England (HEE) funded project manager in the biggest NHS trust in the South West.

Nikki is committed to delivering high quality patient-centred care and improving patient experience.

Following a period as Acting Chief Nurse, Nikki was appointed as the Executive Chief Nurse on a substantive basis from January 2023, following a competitive selection and recruitment process.

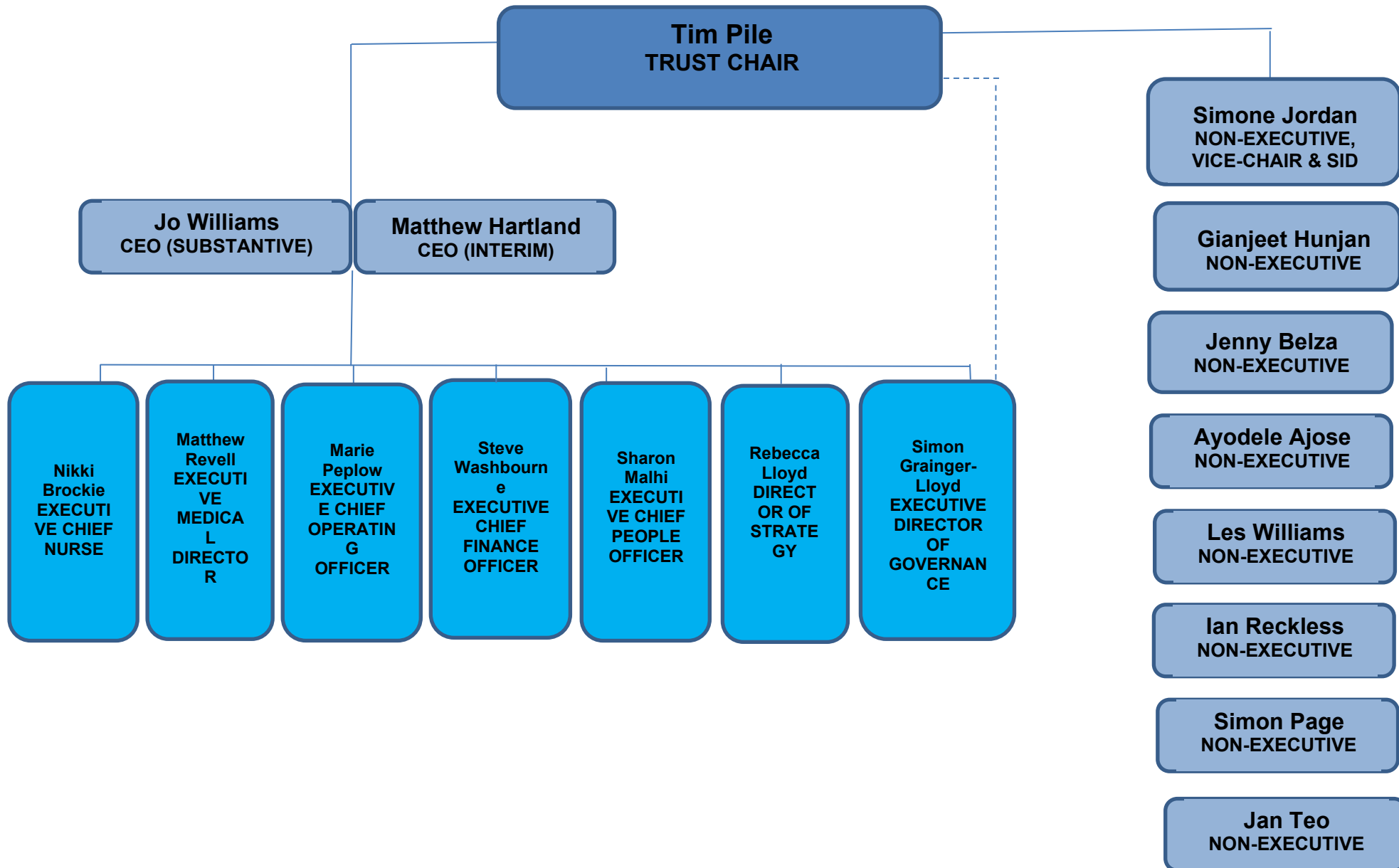


**Rebecca Lloyd – Director of Strategy**

Rebecca joined the ROH in 2016, having started her NHS career in 2011 at a large acute Trust working in Strategy & Business Development and Community & Therapies. She has an undergraduate degree in Law, and post graduate qualifications in Psychotherapy and Executive Coaching and Mentoring. Rebecca is responsible for strategy development, strategic partnerships, service improvement, programme management office (PMO), communications and the Royal Orthopaedic Charity.

Rebecca served as a Trustee of James Brindley Academy from 2017-2024 and remains passionate about improving links between education and healthcare.

Trust Board structure as at 31 March 2025



## 1.1 Directors' interests and independence

The Trust's Register of Directors' interests is open to the public and can be accessed by writing to:

Director of Governance & Data Protection Officer (DPO)  
The Royal Orthopaedic Hospital NHS Foundation Trust  
Bristol Road South  
Northfield  
Birmingham, B31 2AP

The Board considers all Non-Executive Directors are independent in character and judgement and there are no relationships or circumstances which are likely to affect, or appear to affect, their judgement.

## 1.2 Balance, completeness and appropriateness of the Board of Directors

The purpose of the Trust's Board is to govern effectively and in doing so build patient, public and stakeholder confidence that their health and healthcare is in safe hands. The Board of Directors is made up of Non-Executive and Executive Directors.

As at 31 March 2025, the Trust had two Non-Executives on its Board with a clinical background; a Non-Executive with financial expertise, who is a qualified accountant; two Non-Executives with a clear commercial focus; a Non-Executive with skills and experience in workforce and innovation & improvement; a Non-Executive with operational, NHS commissioning and strategy experience; and a Non-Executive with a legal background. The Chair has a wide range of experience in the private sector.

Taking the wide range of experience of the Board of Directors as a whole, the balance and completeness of the Board is felt to be appropriate.

## 1.3 Board of Directors' discharge of obligations

Under law each year the Directors are obliged to prepare financial statements and present these to the Trust's Council of Governors and members at its Annual General Meeting.

The Directors are responsible for the adoption of suitable accounting policies and their consistent use in the financial statements, supported where necessary by reasonable and prudent judgements.

The Directors confirm the above requirements have been complied with in the financial statements. The Directors are also responsible for maintaining adequate accounting records and sufficient internal controls to safeguard the assets of the Trust and to prevent and detect fraud or any other irregularities.

The Directors also confirm the Board has conducted a review of the effectiveness of its system of internal controls as set out in the Annual Governance Statement.

## 1.4 Meetings of the Non-Executive Directors

In accordance with the Foundation Trust Code of Governance during the year, as and when required, the Chair held meetings with the Non-Executive Directors without the Executive Directors being present. In addition, the Chair systematically held regular meetings prior to formal Board meetings with Non-Executive Directors without Executive Directors being present.

## 1.5 Significant Commitments of the Trust Chair

Tim Pile is a member of Council of Aston University.

## 1.6 Appointment of Chair and Non-Executive Directors and process for appointing Non-Executive Directors

During 2024/25 the Non-Executive cadre of the Board comprised eight Non-Executive Directors plus the Chair.

The Council of Governors has the power to appoint and remove the Chair and Non-Executive Directors of the Trust. The Council of Governors is supported by a joint Nominations and Remuneration Committee.

In accordance with the Trust's constitution, Non-Executives and the Trust Chair are appointed for an initial term of three years, with the possibility of reappointment for a further term once this has expired. Extension beyond this is subject to agreement by the Council of Governors and the Integrated Care Board, that the individuals remain independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement.

There was one new Non-Executive appointments during the year, with Jan Teo joining the Trust Board as part of the Board's succession plan. The appointment process was supported by an external recruitment agent and the formal interview process included members of the Council of Governors, who subsequently offered a recommendation on the appointments to the wider Council which was approved.

### 1.7 Removal of the Chair or Non-Executive Director

Removal of the Chair or another Non-Executive Director requires the approval of three-quarters of the members of the Council of Governors.

### 1.8 Statement of operation of the Board of Directors and Council of Governors

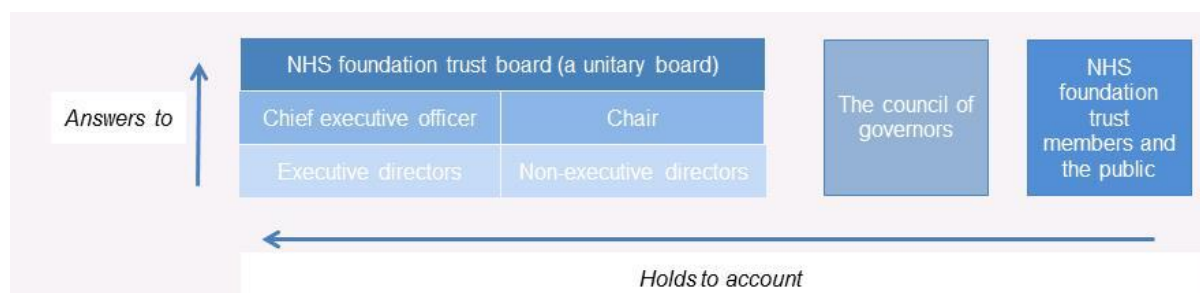
The Board of Directors comprises Executive Directors and Non-Executive Directors. The Executive Directors are employees, led by the Chief Executive and they are responsible for the day-to-day management of the Trust.

The Non-Executive Directors are not employees and bring an independent perspective to Board meetings. They have a particular duty to challenge decisions and proposals made by Executive Directors. The Board is led by the Chair who is also a Non-Executive Director. A Vice Chair is in place, this being Simone Jordan who is also the Senior Independent Director (SID). These duties were agreed by the Council of Governors during the previous and recent financial year.

The primary role of the Board of Directors is to lead the Trust within the context of its strategy, whilst ensuring successful financial stewardship of the Trust. To achieve this, the Board receives regular reports on all aspects of its business to enable appropriate decisions to be taken.

The Board has a schedule of reserved decisions, which lists out decisions which only the Board can make and a scheme of delegation which details areas of responsibility delegated to committees and individual Directors/Managers.

The Trust's "chain of accountability" – including the position of the Council of Governors - is shown below:



The Chair of the Board of Directors is also the Chair of the Council of Governors and he is responsible for ensuring the Board and Council work effectively together.

A key role of the Council of Governors is to oversee the work of the Board and the Board and Council have agreed a statement that defines how each will operate and how any disagreements will be resolved.

The overriding role of the Council of Governors is to hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors and to represent the interest of the Trust's members and the public. Notwithstanding this, the Board of Directors and Council of Governors at the Royal Orthopaedic Hospital NHS Foundation Trust view their interaction as primarily one of constructive partnership with both the Board and Council seeking to work effectively together in their respective roles.

The Governors are responsible for appointing and removing the Chair and the Non-Executive Directors and set their terms of office. The Trust's auditors are appointed by the Governors and the Governors and the Board must, by majority, agree changes to the Constitution.

The Board is collectively responsible for the performance of the Trust. The general duty of the Board of Directors, and each director individually, is to act with a view to promoting the success of the organisation to maximise the benefits for members of the Trust as a whole and the public.

The Board of Directors:

- provides entrepreneurial leadership within a framework of prudent and effective controls, which enables risk to be assessed and managed;
- is responsible for ensuring the Trust complies with its licence, Constitution, mandatory guidance issued by NHS England, relevant statutory requirements and contractual obligations;
- sets the Trust's strategic aims, taking into consideration the views of the Council of Governors, ensuring the necessary financial and human resources are in place for the Trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance;
- is responsible for ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health & Social Care (DHSC), NHS England, the Care Quality Commission (CQC) and other relevant NHS bodies;
- ensures the Trust functions effectively, efficiently and economically; and
- sets the Trust's vision, values and standards of conduct and ensures that its obligations to its members are understood, clearly communicated and met.

Informal and frequent communication between the Governors and the Directors is an essential feature of a positive and constructive relationship which benefits the Trust and the services it provides. The Senior Independent Director and Chair encourage informal communication on behalf of the Board of Directors. This includes discussions between individual Governors and the Chair, the Chief Executive or a Director, through the office of the Chief Executive or any other person appointed to perform the duties of the Chief Executive to the Board.

Communications initiated by the Council of Governors, and intended for the Board of Directors, are conducted in usual times, as follows:

- Specific requests by the Council of Governors are made through the Chair to the Board of Directors;
- Any Governor has the right to raise specific issues at a duly constituted meeting of the Council of Governors through the Chair. In the event of disagreement, two-thirds of the Governors present must approve the request. The Chair will raise the matter with the Board of Directors and provide the response to the Council of Governors; and
- Joint informal meetings take place between the Council of Governors and the Board of Directors as and when necessary.

## 1.9 Working with Governors and Members

The Royal Orthopaedic Hospital NHS Foundation Trust is a membership organisation with a membership which consists of two constituencies of staff members and two constituencies of the general public. Members in each constituency vote to elect governors and can also stand for election themselves.

The Trust is locally accountable and it is the Council of Governors who collectively bind the Trust to its patients, service users, staff and stakeholders. The Council of Governors consists of elected members and appointed individuals who represent both members and other stakeholder organisations and the Governors act as a link between patients, the public and the Board of Directors.

Members of the Board and, in particular, the Non-Executive Directors, develop an understanding of the views of Governors and Members about the Trust through a number of ways, including:

- Attendance at Council of Governors meetings by the Non-Executive Directors, the Chief Executive and Executive Team colleagues who brief the Governors on the Trust's strategy and current developments and answer questions to ascertain their views;

- At meetings, Non-Executive Directors report on their role on the Board and their Committee responsibilities. At meetings a question-and-answer session is held. Non-Executive Directors also account to the Governors for key Board decisions;
- Governors are invited to attend public Board meetings; and
- Non-Executives and Governors are invited to participate in multi-disciplinary quality assurance walkabouts.

## 1.10 Evaluation of the Trust Board & Committees

Each Board and Committee agenda includes an item for some reflection on the effectiveness of the meeting. During 2024/25 there was a continued focus on upward reporting on matters of positive assurance, risks or concerns requiring Board attention, decisions made at the meetings and major work commissioned or underway.

In 2023/24, formal internal self-assessment of the Board Committees was undertaken. The action plans for the Committees were developed and is considered as a routine item for discussion by the Committee in 2024/25 with progress being reported upwardly to the Trust Board.

Executive Directors are set objectives, performance against which are evaluated by the Chief Executive. The Chief Executive's own performance is evaluated by the Chair. The Non-Executive Directors' objectives are set by the Chair; their evaluation is carried out by the Chair, informed by feedback from other Board members. The results are shared with the Council of Governors. The Chair's appraisal is carried out by the Senior Independent Director, facilitated by the Director of Governance, with input from the Lead Governor. The results are shared with the Council of Governors.

During 2024/25 a self-assessment against the CQC's well led framework was undertaken, which captured an evaluation of the effectiveness of the Board and the governance structures below. Further to this, a self-assessment against the NHSE Insightful Provider Board guidance was undertaken and the action plan associated with this will be monitored in 2025/26.

## 1.11 Board and Committee Membership and Attendance

The Board continually reviews the structure of its Board Committees with a view to improving upward reporting and the escalation of issues.

A number of Committee meetings this year have been held virtually, a practice that commenced during the pandemic, however this is kept under review to ensure that effectiveness of the committees is adequately maintained. All Trust Board meetings and meetings of the Staff Experience & OD Committee have returned to meeting physically.

Committee membership is also kept under review and there have been some changes this year, with Jan Teo joining the Staff Experience & OD Committee.

The Board and Committee has benefited during the year from the services of a Corporate Services Manager who takes responsibility for the administration of the main meetings.

### 1.11.1 Trust Board

The Royal Orthopaedic Hospital's Trust Board is a unitary board which means that within the Board of Directors the Non-Executive Directors and the Executive Directors share the same liability. All directors, Executive and Non-Executive, have responsibility to constructively challenge the decisions of the Board and help develop proposals on priorities, risk mitigation, values, standards and strategy. The Non-Executive Directors have a particular duty to ensure appropriate challenge is made and have to satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management and governance are robust and implemented.

A key strength of the unitary board is the opportunity to exchange views between Executive and Non-Executive Directors, drawing on and pooling their experience and capabilities with all Board members sharing corporate responsibility for formulating strategy, ensuring accountability and shaping culture.

Board meetings are held on a regular basis and are chaired by the Trust Chair. There were ten full meetings of the Trust Board during the year plus one special meeting to approve the annual report and accounts. There was also a separate workshop held, focussed on the plans to secure an improved financial balance over the coming months.

Although the Board exercises all the powers of the Trust some powers may be delegated to a Committee of Directors or to an Executive Director.

ATTENDANCE											
MEMBER	10/04/2024	01/05/2024	05/06/2024	03/07/2024	04/09/2024	02/10/2024	06/11/2024	04/12/2024	05/02/2025	05/03/2025	TOTAL
Tim Pile (Ch)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Ian Reckless	✓	✓	✓	✓	✓	✓	✓	A	A	✓	8/10
Simone Jordan	A	✓	A	✓	✓	✓	✓	✓	✓	✓	8/10
Gianjeet Hunjan	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	9/10
Ayodele Ajose	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	9/10
Les Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Simon Page	✓	✓	✓	A	A	✓	✓	A	✓	✓	7/10
Jenny Belza	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	9/10
Jan Teo	✓	✓	✓	✓	✓	✓	✓	A	A	✓	8/10
Jo Williams	✓	✓	✓	✓	✓						5/5
Matthew Hartland						✓	✓	✓	✓	✓	5/5
Matthew Revell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Nikki Brockie	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Marie Peplow	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/10
Stephen Washbourne	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	9/10
Sharon Malhi	✓	✓	✓	✓	✓	✓	✓	✓	✓	A*	9/10
Simon Grainger-Lloyd	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	9/10

**KEY:**

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		

\* Apologies tendered as attending a national event on behalf of the ROH, mandated for all NHS trusts

## Board Committees

During 2024/25 the Board was supported by the following committees as detailed below.

### 1.11.2 Audit Committee

During the year, the Chair of the Audit Committee was Gianjeet Hunjan, a Non-Executive Director with a professional background in finance and accountancy.

**Meetings**

During 2024/25, the Audit Committee met on five formal occasions.

The attendance at these meetings is as below:

MEMBER	MEETING DATE					TOTAL
	29/04/24	24/06/24	19/07/24	15/11/24	17/01/25	
Gianjeet Hunjan (Ch)	✓	✓	✓	✓	✓	5/5
Les Williams	✓	✓	✓	A	✓	4/5
Jenny Belza	A	✓	✓	A	A	2/5
<b>Executive Directors in attendance</b>						
Steve Washbourne	✓	✓	✓	✓	✓	5/5
Matthew Revell	✓	✓	✓	✓	✓	5/5
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	5/5

**KEY:**

✓	Attended	A	Apologies tendered
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During the year, Non-Executive representation from the Quality & Safety Committee was from Jenny Belza.

Meetings were also attended routinely by representatives from the Trust's provider of External Audit and Internal Audit (including Counter Fraud services). During the year, the Audit Committee invited a number of guests to present progress on actions arising from some Internal Audit reviews.

Prior to or after each meeting, the auditors were offered a meeting in private with the members of the Audit Committee to discuss any matters or raise concerns where required, without any members of the Executive Team or guests present.

The Audit Committee's minutes were submitted to the Board of Directors for consideration as part of the private Board sessions, supported by a full assurance report in public, detailing the key points of discussions at the meeting, matters to escalate and decisions taken by the Committee.

**Work undertaken 2024/25**

The Committee dealt with the following key matters:

**Routine Work**

The Committee:

- Reviewed and approved the Annual Report and Accounts for 2023/24 (in June 2024), together with the Head of Internal Audit's report, Going Concern statement and Annual Governance Statement (and other disclosures) contained within.
- Received and reviewed the 2023/24 Audit report from the External Auditors.
- Improved the focus on clearing outstanding audit recommendations, resulting in a review of all outstanding recommendations and an improvement in the closure of actions including those raised by the prior Internal Audit function.
- Continued to strengthen a supportive working relationship with the Quality & Safety Committee (QSC). A Non-Executive member of the Quality & Safety Committee is included within the membership of the Audit Committee and the Executive

Medical Director is also a regular attendee at the meeting. The Audit Committee chair is also a member of the Quality & Safety Committee.

- Received and reviewed the Deloitte audit planning report highlighting the key risks they had considered in planning their audit work.
- Received and reviewed a report detailing the outcome of the Value for Money assessment undertaken by Deloitte.
- Received and reviewed from Counter Fraud (KPMG) updates on the counter fraud programme for 2024/25.
- Received and reviewed a benchmarking report of anti-fraud, which presented a positive picture of the robust control environment in respect of fraud in the Trust compared to elsewhere.
- Reviewed and approved the Internal Audit charter.
- Received and reviewed regular update reports from Internal Audit (KPMG) and reviewed all significant internal audit reports. The internal audit plan remained on schedule during the year.
- Received and reviewed regular updates on the tracking of implementation of all internal and external audit recommendations.
- Reviewed and approved the proposed internal audit plan for 2024/25. This plan had been aligned to the Board Assurance Framework (BAF) and other risk mechanisms within the organisation.
- Received and reviewed regular updates on the BAF. The Committee was also updated on the work undertaken to restructure the BAF to align it to the new five-year strategy and to take into account best practice suggestions seen elsewhere by Internal Audit.
- Received and reviewed routine updates on payments made for losses or compensation and waivers & breaches of Standing Financial Instructions. The Committee challenged when needed, the use of single tenders, given that the use of these had the potential to compromise best Value for Money.
- Received and reviewed updates on the statutory registers, concerning hospitality and declarations of interest and urged that staff be encouraged to make comprehensive and timely declarations when needed.
- Received and reviewed routine updates on the work to achieve compliance with the requirements of the Data Security and Protection Toolkit.
- Approved its revised workplan for 2025/26.

#### Ad hoc matters

- The Committee received updates on the work to strengthen Data Security Protection Toolkit following an internal audit.
- The Committee received an overview of the work being led by the Chief Nurse to address health inequalities by the Trust and within the Birmingham and Solihull Integrated Care System.

#### Work Plan 2025/26

For 2025/26, the Audit Committee will continue with its routine work as well as to deal with ad hoc requirements that will emerge from time to time.

The Committee has set expectations that the process for ensuring that decision-making staff adhere closely to the requirements of the Trust's Conflicts of Interest policy is strengthened.

The Committee will retain a close oversight of the progress with minimising cybersecurity risks and achieving compliance with the Data Protection and Security Toolkit.

Given the ongoing financial pressures at a national level and on the organisation, close scrutiny of the Trust's Going Concern status will remain also an area of prime focus during the year.

### 1.11.3 Quality & Safety Committee

The Quality and Safety Committee has designated responsibility for oversight of clinical risk management and is chaired by Ian Reckless, a Non Executive Director of the Trust with a clinical background. Gianjeet Hunjan is also a member of the Committee creating a close link with the work of the Audit Committee. Jenny Belza, a Non-Executive with a clinical background, is also a member of the Quality & Safety Committee, and also provides updates to the Audit Committee as part of its membership.

## Meetings

During 2024/25 the Quality & Safety Committee met on six occasions, following the decision in early 2023 to move the mode of operation to meeting on alternate months. This reflected the confidence in the work of the Quality & Safety Executive in relation to more operational quality matters and the scope of the quality & safety agenda in a small specialist organisation.

The attendance at these meetings is shown overleaf.

MEMBER	MEETING DATE						TOTAL
	22/05/2024	24/07/2024	25/09/2024	20/11/2024	22/01/2025	26/03/2025	
Ian Reckless (Ch)	✓	✓	✓	✓	✓	✓	6/6
Gianjeet Hunjan	✓	✓	✓	✓	✓	✓	6/6
Jenny Belza	✓	✓	✓	✓	✓	✓	6/6
Jo Williams	A	✓	✓	✓	✓	✓	1/2
Matthew Hartland				✓	✓	✓	3/3
Nikki Brockie	✓	✓	✓	✓	✓	✓	5/6
Matthew Revell	✓	✓	A	✓	✓	A	5/6
Marie Peplow	✓	✓	✓	✓	✓	✓	6/6
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	6/6

**KEY:**

✓	Attended	A	Apologies tendered
	Not in post/not required		

The Quality & Safety Committee's minutes are submitted to the Board of Directors for consideration as part of the private Board sessions, supported by a full assurance report in public, detailing the key points of discussions, risks noted & matters to escalate and decisions taken by the Committee.

## Work undertaken 2024/25

The Committee dealt with the following key matters:

### Routine Work

The Committee received upward reports from the Trust's Clinical and Corporate Governance groups, namely:

- Quality & Safety Executive
- The Audit, Quality Improvement, Learning & Assurance panel (AQILA)
- Cancer Board
- Infection Control Committee
- Safeguarding Committee
- Patient Experience & Engagement Group
- Health & Safety Group
- Human Tissue Authority Advisory Group
- Research & Development Group

In year the Committee continued to receive the upwards reports using the standard assurance template used by the Board Committees who report upwardly to the Trust Board.

The Committee during the year, has received routine reports on:

- Quality & Patient Safety performance
- Litigation and claims
- Preparation for and implementation of the Patient Safety Incident Response Framework (PSIRF)
- Progress with Quality Priorities
- Performance against CQUINs
- Patient Reported Outcome Measures (PROMS) and the National Joint Register (NJR)
- Controlled Drugs
- Learning from Deaths
- Nurse staffing
- 'Flu vaccination
- CQC engagement work
- Compliance with the IPC Board Assurance Framework
- Patient Experience
- Updates from the ICB Quality Committee
- Quality & Safety risks on the corporate risk register

The following annual reports were received, in accordance with the Committee's routine cycle of business:

- Medicines Safety Officer
- Complaints
- Safeguarding
- Vulnerabilities
- Accountable Officer for Controlled Drugs
- Infection Prevention & Control
- Fire safety
- Radiation Safety Human Tissue Authority annual report

#### **Single issue or non-routine reports**

During the year, the Committee received some specific reports providing assurance on particular key issues or single-issue updates, these being:

- Readmissions
- Service Accreditation
- Learning Disability and Autism Action Plan & Learning Disability Standards
- Antimicrobial Consumption Report
- Health Inequalities action plan
- Surgical site infections
- Endoscopic spinal surgery service
- Violence Prevention and Reduction Standards compliance

- Quality Assurance walkabouts
- OH Medicines Optimisation Plan 2025-2028
- 'Call for Concern' update
- Never Events Assessment and Declaration Process
- Preventing Future Deaths

**2025/26 Work Plan**

For 2024/25, the Quality & Safety Committee will continue with its routine work as well dealing with ad hoc requirements that will emerge from time to time or remitted from the Board and/or Audit Committee.

The revised workplan was presented to the Quality & Safety Committee for its approval in November 2024 which is not likely to change significantly for the coming year.

There will remain a focus on improving the effectiveness of the Committee during 2025/26, with particular focus on seeking appropriate assurance on matters within its remit and understanding how lessons learned from incidents, complaints, litigation and clinical audit are disseminated & acted upon and the linkages to the Trust's Quality Improvement work.

**Quality & Safety Committee Effectiveness**

An item is included on the agenda of each meeting to review the effectiveness of the meeting and of the Committee in general.

Following the effectiveness review that was undertaken by the committee in 2023, the Committee has received regular updates on progress with these actions during the year with the final action completed with the reshaped Quality & Patient Safety report that is now presented at each meeting.

**Conclusion**

The Quality & Safety Committee has functioned well during 2024/25 and is operating effectively, providing clear and adequate assurance upwards to the Trust Board across a comprehensive range of matters of a quality & patient safety nature.

**1.11.4 Finance and Performance Committee**

The Committee was chaired Les Williams throughout 2024/25. The Trust Chair and other members of the Board, although not formal members, attended the committee meetings from time to time during the year. The Committee meets monthly (apart from August and December) and regularly reviews finance and performance-related risks through consideration of an extract of the Corporate Risk Register.

A key area of focus for the Committee during the year was on the operational and financial performance of the Trust. The Committee also continued to receive upward reports from the Service Improvement Board, Information Governance Group, the Green Board and the Temporary Workforce Group.

MEMBER	MEETING DATE										Total
	30/04/24	28/05/24	25/06/24	30/07/24	24/09/24	29/10/24	26/11/24	28/01/24	25/02/24	25/03/25	
Les Williams (Ch)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Gianjeet Hunjan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Ayodele Ajose	✓	A	✓	A	A	A	✓	✓	A	✓	1/2
Simon Page	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	9/10
Jan Teo	✓	✓	✓	✓	A						4/5
Jo Williams	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	4/5

Matthew Hartland						A	✓	✓	✓	A	3/5
Steve Washbourne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Marie Peplow	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/10
Sharon Malhi	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Nicola Brockie	A	✓	✓	A	A	A	✓	✓	✓	✓	6/10
Matthew Revell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	9/10

**KEY:**

✓	Attended	A	Apologies tendered
			Not in post/not required to attend

**1.11.5 Staff Experience and Organisational Development (OD) Committee**

The Staff Experience & OD Committee was established to provide enhanced oversight of the Trust's workforce agenda. The Committee is chaired by a Non-Executive, Simone Jordan. The Committee usually meets on alternate months according to its workplan, however during this year it met four times reflecting a readjustment following the change in the meeting schedule.

The focus for the Committee is to provide the Board with assurance concerning the arrangements and progress with performance against key workforce targets and delivery of key activities in support of the Trust's workforce strategies, such as the People Plan, Inclusion Strategy and Wellbeing Plan. The Committee also receives updates from the Education and Training function of the Trust. As with the Quality and Safety Committee and the Finance & Performance Committee, the Staff Experience & OD Committee regularly reviews workforce performance and related risks through consideration of a workforce dashboard and a Risk Register. The Committee also receives at each meeting a presentation from a member of staff or team outlining their experience of working at the ROH and have the opportunity to make suggestions for ways in which the life of staff working at the Trust might be improved.

MEMBER	MEETING DATE				TOTAL
	26/06/24	28/08/24	23/10/24	26/02/25	
Simone Jordan (Ch)	✓	✓	✓	✓	4/4
Ayodele Ajose	✓	A	✓	✓	1/2
Simon Page	A	✓	✓	✓	3/4
Jan Teo			✓	✓	2/2
Jo Williams	✓	✓	✓	✓	2/2
Matthew Hartland			✓	✓	2/2
Matthew Revell	✓	✓	A	✓	3/4
Marie Peplow	✓	✓	A	✓	3/4
Sharon Malhi	✓	A	✓	✓	3/4
Simon Grainger-Lloyd	✓	✓	✓	A	3/4
Nicola Brockie	✓	✓	A	✓	3/4

**KEY:**

✓	Attended	A	Apologies tendered
	Not in post/not required to attend		

Also in attendance at this meeting are the Head of OD & Inclusion, Head of HR, and Head of Education & Training and Deputy Chief People Officer.

### 1.11.6 Charitable Funds Committee

The Trust Board is the corporate trustee for the charitable funds of the Trust. Charitable funds are examined separately from exchequer funds and the Trustees discharge their responsibilities independently from the Foundation Trust itself.

The Committee was chaired by Ayodele Ajose, one of the Non-Executive Directors, during the year.

The Committee returned to a more frequent meeting cycle during 2024/25 and met four times during the year.

The Corporate Trustee comprises all voting members of the Trust Board. Also, in attendance includes members of the ROH Charity, members of the finance team and patient representatives where available.

During the year, the Committee considered a number of requests for funding, an update on the financial health of the charity and the annual report and accounts, which was considered and approved at the November 2024 meeting.

TRUSTEE	DATE				TOTAL
	11/04/24	19/06/24	21/11/24	20/03/25	
Ayodele Ajose (Ch)	✓	✓	✓	✓	4/4
Tim Pile	A	✓	✓	✓	3/4
Simone Jordan	A	A	✓	✓	2/4
Gianjeet Hunjan	✓	✓	A	A	2/4
Les Williams	✓	A	✓	✓	3/4
Dr Ian Reckless	✓	✓	✓	✓	4/4
Simon Page	✓	A	✓	✓	3/4
Jenny Belza	A	A	✓	✓	2/4
Jan Teo	A	✓	A	✓	2/4
Stephen Washbourne	✓	✓	✓	✓	4/4
Jo Williams	✓	✓			2/2
Matthew Hartland			✓	✓	2/2
Matthew Revell	✓	✓	A	✓	3/4
Marie Peplow	A	✓	✓	✓	3/4
Nicola Brockie	✓	✓	✓	A	3/4
Simon Grainger-Lloyd	✓	✓	✓	✓	4/4
Sharon Malhi	✓	✓	✓	✓	4/4
Rebecca Lloyd			✓	✓	2/2

**KEY:**

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		

### 1.11.7 Nominations and Remuneration Committee (Executive Directors)

The Nominations and Remuneration Committee is chaired by a Non-Executive Director, Simone Jordan and comprises all the Non-Executive Directors. The Chief Executive is a member but, in the case of matters relating to the Chief Executive themselves, they must withdraw from the Committee. The Chief People Officer supports and advises the Committee and is invited to join the meetings should the agenda benefit from this attendance. The Committee meets four times per year and operates to a formal workplan that was refreshed during the year.

The Committee serves a dual purpose:

- To review the structure, size and composition of the Executive element of the Board (including skills, knowledge and experience) required of the Board and make recommendations to the Board or Council of Governors where appropriate with regard to any changes. It also considers succession planning, appraisal and development plans. The Committee identifies and nominates suitable candidates to fill Executive Director vacancies. The Committee liaises closely with the Council of Governors' Nominations and Remuneration Committee.
- The Remuneration Committee has delegated responsibility for setting the remuneration for all Executive Directors, including pension rights and any compensation payments. The Committee also recommends and monitors the level and structure of remuneration for senior management. The Committee provides the Board with advice concerning the terms and conditions of employment, including the remuneration packages for the Chief Executive and the Executive Directors. The Committee also seeks assurance on the robustness of the plans for the delivery of Trust's reward and recognition strategy for the Chief Executive and Executive Directors.

MEMBERS	DATE		TOTAL
	04/09/2024	02/10/2024	
Simone Jordan (Chair)	✓	A	1/2
Tim Pile	✓	✓	2/2
Gianjeet Hunjan	✓	✓	2/2
Les Williams	✓	✓	2/2
Ayodele Ajose	✓	✓	2/2
Ian Reckless	✓	✓	2/2
Jenny Belza	✓	✓	2/2
Simon Page	A	A	0/2
Jan Teo	A	A	0/2
Jo Williams	✓		1/1

KEY:

✓	Attended	A	Apologies tendered
	Not in post/not required to attend		

### 1.12 Cost allocation and charging guidance

The Trust has complied with the cost allocation and charging guidance, (Chapter 6 of HM Treasury Managing Public Money).

### 1.13 Political Donations

There were no political donations during the financial year.

## 1.14 Better Payment Practice

The Trust paid 82.8% of invoices (78.3% by value) within 30 days against the target of 95%, as detailed below:

	Actual	Actual
	31/03/2025	31/03/2025
	Number	£'000
<b>Non-NHS</b>		
Total bills paid in the year	12,660	55,105
Total bills paid within 30 days	10,568	45,858
Percentage of bills paid within 30 days	<b>83.5%</b>	<b>83.2%</b>
<b>NHS</b>		
Total bills paid in the year	265	6,324
Total bills paid within 30 days	136	2,245
Percentage of bills paid within 30 days	<b>51.3%</b>	<b>35.5%</b>
<b>Total</b>		
Total bills paid in the year	12,925	61,429
Total bills paid within 30 days	10,704	48,103
Percentage of bills paid within 30 days	<b>82.8%</b>	<b>78.3%</b>

The Trust did not incur any late payment penalties during 2024/25 under the Late Payment of Commercial Debts (Interest) Act 1998 (2023/24: £nil).

## 1.15 NHS England's well-led framework

The Board commissioned an external well led assessment undertaken in 2019 by the consultancy arm of Grant Thornton UK LLP. This was the first developmental review of leadership and governance using the NHS England well led framework that the Trust had undertaken since its authorisation as a Foundation Trust. The action plan developed in response to the recommendations made by the review has been delivered. Further work will be undertaken during 2025/26 to revisit the action plan to ensure that any changes made as a result have been sustained. This will be alongside the work already underway to prepare for the next CQC inspection, where a key component of this has been the self- assessment against the Well Led domain that was undertaken in 2024/25. The action plan developed will improve compliance and address areas of shortfall where identified.

## 1.16 How the Foundation Trust has had regard to NHS England's quality governance framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework and a summary of action plans to improve the governance of quality

Quality governance is discussed in more detail in the Annual Governance Statement (Section 8); this section gives a brief overview of the arrangements in place to govern service quality.

The Board receives assurance on quality governance through the Board Assurance Framework, performance against a wide range of indicators in the monthly Finance and Performance Overview, through assurance provided by the Quality and Safety Committee, which considers in detail a comprehensive report on Quality and Patient Safety and by the performance against a range of workforce indicators considered by the Staff Experience & OD Committee.

The Quality and Safety Committee provides upward assurance to the Board on the activities undertaken by its subgroups covering particular aspects of quality. Much work has been undertaken during the year to strengthen the quality of information provided to the Quality and Safety Committee, including the ongoing work of the Quality & Safety Executive.

Work has continued throughout the year to develop enhanced approaches to data reporting through the continuous refinement of the Finance and Performance Overview, Quality and Patient Safety report and Workforce overview to enable greater and more

informed scrutiny. Some important work has been undertaken during the year to develop an integrated performance dashboard. The dashboard will be presented to each of the main Board committees to allow better triangulation and visibility of data from a range of sources.

There is a process of escalation of risk related to quality throughout the Trust; much work has been undertaken during the year to cleanse and refine existing risk registers. The Board Assurance Framework (BAF) has also been restructured to realign it to the refreshed Trust strategy and capture more detailed information on the risk mitigations and to demonstrate how the risk scores have changed over time. Further work is planned during 2025/26 to allow the Committees considering the various extracts of the BAF relevant to their remit, to offer a view to the Board as to the adequacy of the risk mitigation.

There has continued to be a focus this year on delivery of training on risk management and more systematically creating a higher level of awareness in the organisation about risk identification and management. The annual internal audit undertaken by KPMG on the BAF and risk management in early 2025, recognised the progress and the strengthened risk management framework in the organisation.

There has been a return to Non-Executive Board members carrying out informal walkabouts in which they gain first-hand experience regarding the quality of care and the views of patients and staff and others and a formal schedule for these visits was published in 2024/25. The formal programme of Quality Assurance walkabouts has been reintroduced led by the Patient Experience function. There are plans to improve the reporting of the outcome and action plans from these visits to the Quality & Safety Committee. In addition to the Quality Assurance walkabouts, during the year the 'Chat & Check' Executive walkabouts initiative continued. This allows members of the Executive Team to visit all areas of the Trust by rotation in pairs and hold informal conversations with staff around their experience of working at the Trust which may identify quality issues that need to be handled.

Assurance is obtained routinely on compliance with CQC registration requirements through Directors and Senior Managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems to support those standards. In 2024/25, the CQC readiness programme progressed, which will be delivered during further during 2025/26 and reflects the requirements of the new CQC Single Assessment Framework. At a divisional and corporate level, an assessment will be undertaken against the new CQC framework to identify where there may be shortfalls or a lapse in sustainability of actions or processes previously implemented.

During the year, the Trust Board agenda included a regular slot to seek assurance on the adequacy of the Trust's Freedom to Speak Up framework. An internal audit into Speaking Up in the organisation was also conducted by the Trust's internal auditors which provided a high level of assurance.

A significant piece of work which commenced in 2022/23 and culminated in 2023/24 was the implementation of the national Patient Safety Incident Response Framework (PSIRF). A robust governance structure is now in place, which is overseen at an operational level by the Assistant Director of Governance & Risk. At an Executive level this is overseen by the Chief Nurse and Director of Governance. An annual report into the effectiveness of the PSIRF arrangements was offered during the year to the Quality & Safety Committee and Trust Board.

## 1.17 Our Patient Experience

We aspire to be an outstanding trust that fosters positive experiences for patients and families, continuously striving for improvement through engagement and collaboration. We believe that the most valuable way to enhance our services is by actively listening to individuals' thoughts, feelings, and experiences throughout their care journey and beyond.

Our commitment to involving patients, carers, and the public ensures that their perspectives shape the future of our services. We provide numerous opportunities for them to share their experiences and tell their stories, with all feedback remaining anonymous, valuable, and actionable.

To support this, our Patient Engagement & Experience Group reports to the Board's Quality and Safety Committee, focusing on identifying themes and concerns arising from patient feedback. Additionally, our Patient Participation Group, co-chaired by our Head of Patient Experience and a patient representative, plays a key role in ensuring meaningful engagement.

We are dedicated to listening and learning through a range of initiatives, including:

- Friends and Family Test
- Coffee Catch Ups
- CQC National In-patient surveys
- Engagement events including "walk arounds" and Patient Engagement stands

- Complaints
- Compliments and concerns given to our Patient Advice and Liaison Service (PALS)
- Social media and online feedback
- Healthwatch Liaison and feedback

Members of Healthwatch sit on our Patient Engagement & Experience Group and report on the community's feedback about our services. In 2024 Healthwatch presented a specialised Annual Report regarding feedback and information shared by patients of the ROH with them. The Trust continues to meet regularly with Healthwatch, recognising the importance of independent feedback this provides to our patients, carers and their families.

### **Complaints**

From April 1<sup>st</sup>, 2024, to March 31<sup>st</sup>, 2025, 84 patients, relatives or third parties made a formal complaint to the Trust, this represents a 202% increase from the previous year. 83 of these complaints progressed through the formal complaint route with one being withdrawn. To address this significant increase, several ongoing initiatives have been undertaken, focusing on identifying trends and themes and resolving systemic issues that have directly impacted patient satisfaction.

A key measure of quality concerning how we manage our complaints is the number that we reopen due to the complainant in receipt of the response saying their concerns have not been answered. Between April 2024 and March 2025, the Trust received requests from patients and their families to reopen seven complaints. This represents 8% of the total closed complaints during that same period and all were resolved to the patients satisfaction.

### **Parliamentary and Health Service Ombudsman (PHSO)**

We advise all complainants of their right to refer any complaint they feel we have not resolved adequately to the Parliamentary and Health Service Ombudsman (PHSO). From April 2024 to March 2025, the PHSO initiated one investigation at a patients request, which is currently ongoing.

### **PALS (Patient Advisory Liaison Service)**

During 2024/2025 the Trust has received 594 PALS contacts from patients and relatives. This is a 6% increase in PALS contacts compared with 2023/2024. The Trust continues to strive to improve the service offered to patients to resolve their concerns at the most appropriate level and ensures that every person who wants to raise a concern or complaint has a full explanation of each process to ensure that they are able to make an informed decision as to which option they wish to proceed with.

### **Friends and Family Test (FFT) and sentiment analysis**

We recognise there is no better or more important way of improving our services than by listening to what individuals think, feel and experience throughout their journey. We value all feedback from patients and their families and are committed to identifying where patients provide us with examples of where staff went the extra mile, staff have told us how they feel appreciated when this is shared.

Any feedback identifying areas of good practice or highlighting concerns informs the Trust in learning what has gone well and developing quality improvement programmes to address trends and themes of concerns.

During 2023/24, the Trust decommissioned the "Smiley faces" consoles and reintroduced FFT surveys. In the period from the 1<sup>st</sup> April 2024 to 31<sup>st</sup> March 2025 we have received 14,943 responses and feedback from patients and carers via our Friends and Family Test on their care and experience – an increase of 149% from last year. This significant increase in meaningful feedback has allowed us to analyse recurring concerns and praise, share concerns with responsible departments, enhance training, share best practice and celebrate excellence.

### **Volunteering**

Work continues expanding our volunteer base and developing roles that not only enhance our patient experience but satisfaction for our volunteers who give up their time and effort so willingly. This work includes the development of new roles to ensure the volunteering programme is responsive to the needs of patients, staff, and the Trust.

## 1.18 Stakeholder Relations

During the year, the Trust has continued to develop its place and contribution within the Birmingham and Solihull Integrated Care System (ICS), and wider system partners.

The Trust continues to lead the MSK Transformation Programme, which is a key piece of work involving partners from across the Birmingham and Solihull system and more widely.

The Trust continued Patient Experience & Engagement for a during the year, with good attendance and the continued attendance patient representatives, with initiatives over the year such as:

- The Patient Experience Department continues to engage proactively with all members of the ROH Community. We recently hosted a stand in outpatients to share information and engage with our patients, staff and visitors. We hold Patient Participation Group bimonthly and have active patient members from that group sit on the Patient Experience and Engagement Group. Members of the team also participate in the Quality Safety Walkabouts and attend other patient events such as "Coffee Catch Ups".
- The Department is actively sending PALS and Complaints Satisfaction Surveys out monthly to patients/families/carers who have raised a PALS or formal complaint with us.
- During the last twelve-month period, we have received nearly 15,000 responses from patients and carers via our Friends and Family Test on their care and experience which is well over double the responses we were gaining from FFT and Smiley Faces combined. We can collect this data via paper based forms, online and through a QR code to enable equitable access to all.
- The Patient Experience Department received more formal complaints in 2024/2025 compared to last year which helps to demonstrate that our patients and their families and carers are able to access the processes easily and feel comfortable and supported to raise their concerns.
- In excess of 140 Actions have been created as a result of PALS cases and Formal Complaints this year. Progress against these are reported weekly in the divisional governance meetings. Actions are identified from the issues raised in PALS and Complaints and are a learning and improvement tool to help us continuously improve our services.
- In-depth Surveys continue to go from strength to strength in 2024/2025 with our Volunteers conducting national and targeted surveys across all of our wards, departments and satellite services.
- The Patient Engagement and Experience Group now meets face to face after being an online group during and after covid. All members agree that they find meeting in person much more engaging and beneficial with robust and productive conversations taking place.
- A thematic review was undertaken in January 2025 of feedback received via all media and several ongoing initiatives have been undertaken, focusing on proactive problem solving and resolving systemic issues that have directly impacted patient satisfaction.

To conclude this chapter, two specific statements need to be made as to the consistency of the Annual Report with other corporate documents and a statement to the auditors that the Directors of the organisation have taken all reasonable steps to disclose information to the auditors and to take all steps necessary to identify information of which they are aware which needs to be disclosed.

## 1.19 Material inconsistencies

There are no material inconsistencies between:

- the Annual Governance Statement.
- Annual Board declarations.
- the Annual Report.
- reports arising from Care Quality Commission planned and responsive reviews of the NHS Foundation Trust and any consequent action plans developed by the NHS Foundation Trust.

## 1.20 Statement as to Disclosure to Auditors

For each individual who is a Director at the time that the report is approved:

- So far as the Director is aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware; and

- The Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

A Director is regarded as having taken all the steps that they ought to have taken as a Director in order to do things mentioned above, and:

- made such enquiries of his/her fellow directors and of the company's auditors for that purpose; and
- taken such other steps (if any) for that purpose, as are required by his/her duty as a Director of the company to exercise reasonable care, skill and diligence.



Matthew Hartland  
Chief Executive  
25 June 2025

## Section 2: Remuneration Report

### 2.0 Annual statement on Remuneration

During the year, the Nominations and Remuneration Committee met to review executive pay with a view to considering implementing an annual cost of living pay award in line with ministerial guidance. There were no other substantive discussions around executive pay, other than to agree the terms of the secondment of the substantive Chief Executive to Shrewsbury & Telford Hospitals NHS Trust and those of the incoming Interim Chief Executive.

The Committee sought the advice of the Chief People Officer in assisting the Committee with its decision-making at this meeting who considered the proposal in the context of the plans of other organisations in the Birmingham and Solihull system.

This statement represents the views of Simone Jordan, the Chair of Nominations and Remuneration Committee.

## 2.1 Senior managers' remuneration policy

### 2.1.1 Future policy table: Executive Directors

	Salary and fees	Taxable Benefits	Annual Performance - related bonuses	Long-term Performance-related bonuses	Pension-related benefits	Other Remuneration
<b>Description</b>	Basic pay for Executive role	None	Not Applicable	Not Applicable	NHS Pension Scheme membership	Not Applicable
<b>How that component supports the short and long-term strategic objectives of the foundation trust</b>	To ensure the Trust is well-led and all short and long-term objectives are met, the salary for senior managers must be competitive in order to recruit and retain talented individuals	To ensure senior managers are appropriately compensated for those journeys they have undertaken on behalf of the Trust. The policy for senior managers is the same as that applying to other staff.	Not Applicable	Not Applicable	This enables the Trust to recruit sufficient talent at Executive Director level and accords with custom and practice in the rest of the NHS.	Not Applicable
<b>An explanation of how that component operates</b>	Executive Director Salaries are determined by the Nominations & Remuneration Committee of the Trust Board, informed by benchmark salary derived from established national NHS pay surveys. Executive directors are appointed on a permanent basis under a contract of service at an agreed salary	Trust Expenses Policy applies to Senior Managers. Taxable benefits incurred fell within the scope of this policy. Levels of benefits reflect national terms and conditions for other staff groups to ensure consistency	Not Applicable	Not Applicable	This is determined in accordance with NHS Pension Scheme Benefits. No additional payments are made, including in the event of early retirement.	As determined by national terms and condition of employment

<b>The maximum that could be paid in respect of that component</b>	Fixed salary determined by Nominations & Remuneration Committee	Not Applicable	Not Applicable	Not Applicable	As determined by NHS Pension Scheme Entitlements	As determined by national terms and condition of employment
<b>Where applicable, a description of the framework used to assess performance</b>	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable

**Accompanying notes**

There were no new core components of the remuneration package.

There were no changes made to existing components of the remuneration package other than the pay award referred to above.

The policy on remuneration for other employees is to utilise national terms and conditions of employment, with local policies relating to pay progression.

The approach for senior managers is currently as determined above.

Provisions for the recovery of sums paid to directors and other staff exist where overpayments have been made in error or annual leave taken in excess of entitlement.

## 2.1.2 Future policy table: Non-Executive Directors

	Fee payable	Any additional fees payable for any other duties to the foundation trust	Such other items that are considered to be remuneration in nature
<b>Description</b>	Fee for the Chair, Committee Chairs and other Non-Executive Directors	Not applicable	Expenses incurred in the course of their duties such as public transport, mileage and subsistence as determined by Trust policy.
<b>How that component supports the short and long-term strategic objectives of the foundation trust;</b>	To ensure the Trust is well-led and all short and long-term needs met, the fee for Non-Executive Directors must be competitive in order to recruit and retain talented individuals. Currently fees are nationally set.	Not applicable	To ensure Non-Executive Directors are appropriately compensated for those journeys they have undertaken on behalf of the Trust. The policy for Non-Executive Director expenses is the same as that applying to other staff
<b>An explanation of how that component operates</b>	The Chair and Non-Executive members are entitled to be remunerated by the Trust for so long as they continue to hold office as Chair or Non-Executive member. They are entitled to receive remuneration only in relation to the period for which they hold office. There is no entitlement to compensation for loss of office. The level of remuneration is nationally set by guidance received from NHS England.	Not applicable	Mileage and subsistence allowances for Non-Executive Directors in line with those for other staff
<b>The maximum that could be paid in respect of that component</b>	The rate of remuneration payable to the Chair of the Trust is £45,000 pa (from 1 April 2023) for up to two days per week. The joint Vice Chair and Senior Independent Director is remunerated at a rate of £15,000 pa. The Chair of the Audit Committee is remunerated at £14,567. The current rate of remuneration payable to other Non-Executives is £13,000 pa for approximately three days a month.	Not applicable	Not applicable
<b>Where applicable, a description of the framework used</b>	Performance of Non-Executive Directors is assessed by the Chair annually, and for the Chair, by the Lead Governor and Senior Independent Director	Not applicable	Not applicable

to assess performance			
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## 2.2 Service contracts obligations

There were no obligations on the Trust which:

- were contained in all senior managers' service contracts or;
- were contained in the service contracts of any one or more existing senior managers (not including any obligations in the preceding disclosure); and/or
- the Trust proposes would be contained in senior managers' service contracts to be entered into and which could give rise to, or impact on, remuneration payments or payments for loss of office but which are not disclosed elsewhere in the remuneration report.

## 2.3 Policy on payment for loss of office

All Executive Directors are employed on permanent contracts of employment with a six-month notice period.

No Executive Directors have provision for other payments over and above their contractual notice period or other statutory entitlements, to be made on termination of employment.

During the year there have been no payments made to senior managers for loss of office.

## 2.4 Statement of consideration of employment conditions elsewhere in the Foundation Trust

The pay and conditions of employees were considered when setting the remuneration approach for senior managers by ensuring consistency in determination of non-pay taxable benefits to ensure no favourable treatment for Executive Directors.

The determination of Non-Executive pay is set nationally and we adhere to the current guidance.

In determining pay for Executive Directors, the remuneration levels for other NHS organisations are reviewed, utilising published and recognised national remuneration reports.

The Trust has in place, in addition to the professional indemnity cover provided under the Trust's arrangements with the NHS Litigation Authority, an additional directors & officers liability policy.

Section 3.9.5 of the Staff Report explains the Trust's policy on diversity and inclusion.

## 2.5 Senior managers paid in excess of £150,000

Two directors whose remuneration exceeded £150,000 were in post during the year ended 31st March 2025. The remuneration for each post holder was assessed and benchmarked against comparable Trusts, utilising published independent market salary information and was considered appropriate.

This is the threshold used in the Civil Service for approval by the Chief secretary to the Treasury, as set out in guidance issued by the Cabinet Office. The Cabinet Office approvals process does not apply to NHS foundation trusts but this is considered a suitable benchmark above which NHS foundation trusts should make this disclosure.

## 2.6 Payments to past senior managers

During the year there have not been any payments made to past senior managers.

## 2.7 Disclosures required by Health and Social Care Act

The Trust believes that all relevant disclosures are detailed elsewhere in the report.

## 2.8 Annual Report on Remuneration

### 2.8.1 Service contracts

Name and title	Date of service contract	Term expires	Notice period
Mr Timothy Pile <b>Chair (from 18 January 2021)</b>	1 January 2021 as Chair	1 September 2025	3 months
Mrs Jo Williams* <b>Chief Executive (substantive)</b>	6 May 2019	Not applicable	6 months
Mr Matthew Hartland** Chief Executive (interim)	14 October 2024	31 December 2025	Secondment
Mr Matthew Revell <b>Executive Medical Director</b>	18 February 2019	Not applicable	6 months
Mrs Nicola Brockie <b>Executive Chief Nurse</b>	1 January 2023	Not applicable	6 months
Mrs Marie Peplow <b>Executive Chief Operating Officer</b>	1 September 2019	Not applicable	6 months
Mr Steve Washbourne*** <b>Executive Chief Finance Officer</b>	3 July 2023	Not applicable	6 months
Mr Simon Grainger-Lloyd <b>Executive Director of Governance</b>	4 August 2015	Not applicable	6 months
Mrs Sharon Malhi <b>Executive Chief People Officer</b>	4 April 2022	Not applicable	6 months
Mrs Rebecca Lloyd <b>Director of Strategy</b>	1 March 2016	Not applicable	3 months
Ms Jan Teo <b>Non-Executive Director</b>	1 April 2025	31 March 2027	3 months
Dr Ian Reckless <b>Non-Executive Director</b>	1 November 2022	31 October 2025	3 months
Ms Simone Jordan <b>Non-Executive Director</b>	1 October 2020	30 September 2026	3 months
Ms Ayodele Ajose <b>Non-Executive Director</b>	1 April 2021	31 March 2027	3 months
Mrs Gianjeet Hunjan <b>Non-Executive Director</b>	1 October 2020	30 September 2026	3 months
Mr Leslie Williams <b>Non-Executive Director</b>	1 April 2021	31 March 2027	3 months
Mrs Jenny Belza <b>Non-Executive Director</b>	1 February 2024	31 January 2027	3 months
Mr Simon Page <b>Non-Executive Director</b>	1 February 2024	31 January 2027	3 months

**Notes:**

\* Jo Williams took up a secondment to Shrewsbury & Telford Hospitals NHS Trust from Monday 9 September 2024

\*\* Matthew Hartland joined on secondment from Black Country ICB from 14 October 2024

\*\*\* Steve Washbourne was previously Interim Director of Finance from October 2017

## **2.9 Remuneration Committee**

The Directors' Report (within the Accountability Report) provides the following details in respect of the Remuneration Committee:

- Details of the membership of the Remuneration Committee. This means the names of the Chair and members of the Remuneration Committee should be disclosed (Code of Governance B.2.13).
- The number of meetings and individuals' attendance at each should also be disclosed (Code of Governance B.2.13).

## **2.10 Disclosures required by Health and Social Care Act**

The Trust believes that all relevant disclosures are detailed elsewhere in the report.

## 2.11 Remuneration (subject to audit): 2024-25

Name and Title	2024-25 (12 months to 31 <sup>st</sup> March 2025)						
	Salary and fees	Taxable Benefits**	Annual Performance - related bonuses	Long-term performance -related bonuses	Pension - related benefit (see note below)	Other Remunerat -ion	Total
	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)
	£000	£	£000	£000	£000	£000	£000
Matthew Hartland, Interim Chief Executive Officer (from 14th October 2024)	80-85	0	0	0	0	0	80-85
Joanne Williams, Chief Executive Officer (to 6 <sup>th</sup> September 2024 – currently seconded)	90-95	0	0	0	12.5-15	0	100-105
Nicola Brockie – Executive Chief Nurse**	125-130	1,100	0	0	0	0	125-130
Matthew Revell, Executive Medical Director**	175-180	500	0	0	132.5-135	0	310-315
Steve Washbourne, Executive Chief Finance Officer	150-155	0	0	0	25-27.5	0	175-180
Marie Peplow, Executive Chief Operating Officer	130-135	0	0	0	10-12.5	0	145-150
Simon Grainger-Lloyd – Director of Governance and Data Protection Officer (DPO)	130-135	0	0	0	25-27.5	0	160-165
Sharon Malhi – Chief People Officer **	115-120	1,600	0	0	30-32.5	0	145-150
Rebecca Lloyd – Director of Strategy (from 1 <sup>st</sup> September 2024)	85-90	0	0	0	12.5-15	0	100-105
Tim Pile, Chair	40-45	0	0	0	0	0	40-45
Ayodele Ajose, Non-Executive Director	10-15	0	0	0	0	0	10-15
Simone Jordan, Non-Executive Director	15-20	0	0	0	0	0	15-20
Gianjeet Hunjan, Non-Executive Director	10-15	0	0	0	0	0	10-15
Les Williams, Non-Executive Director	10-15	0	0	0	0	0	10-15
Dr. Ian Reckless, Non-Executive Director *	10-15	0	0	0	0	0	10-15
Jenny Belza, Non-Executive Director	10-15	0	0	0	0	0	10-15
Simon Page, Non-Executive Director	10-15	0	0	0	0	0	10-15
Jan Teo, Non-Executive Director	10-15	0	0	0	0	0	10-15

Notes

\* Dr Ian Reckless was employed by Milton Keynes NHSFT , who recharged the costs of his appointment.

\*\* Salary is net of salary sacrifice arrangements, with the related taxable benefit being recorded with the taxable benefits column.

## 2.12 Remuneration: 2023/24 (Subject to Audit)

Name and Title	2023-24 (12 months to 31 <sup>st</sup> March 2024)						
	Salary and fees	Taxable Benefits	Annual Performance - related bonuses	Long-term performance -related bonuses	Pension - related benefit (see note below)	Other Remunerat-ion	Total
	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)
	£000	£	£000	£000	£000	£000	£000
Joanne Williams, Chief Executive Officer <sup>^</sup>	185-190	0	0	0	0	0	185-190
Nicola Brockie – Executive Chief Nurse <sup>^</sup>	125-130	0	0	0	160-162.5	0	285-290
Matthew Revell, Executive Medical Director <sup>^</sup>	175-180	0	0	0	0	0	175-180
Steve Washbourne, Executive Chief Finance Officer* <sup>^</sup>	135-140	0	0	0	0	0	135-140
Marie Peplow, Executive Chief Operating Officer <sup>^</sup>	125-130	0	0	0	0	0	125-130
Simon Grainger-Lloyd – Director of Governance and Data Protection Officer (DPO) <sup>^</sup>	125-130	0	0	0	25-27.5	0	150-155
Sharon Malhi – Chief People Officer	120-125	0	0	0	27.5-30	0	150-155
Michelle Hubbard – Interim Chief Operating Officer (from January 2024)	30-35	0	0	0	0	0	30-35
Tim Pile, Chair	40-45	0	0	0	0	0	40-45
Richard Phillips, Non-Executive Director (to 31 <sup>st</sup> January 2024)	10-15	0	0	0	0	0	10-15
Ayodele Ajose, Non-Executive Director	10-15	0	0	0	0	0	10-15
Simone Jordan, Non-Executive Director	15-20	0	0	0	0	0	15-20
Gianjeet Hunjan, Non-Executive Director	10-15	0	0	0	0	0	10-15
Les Williams, Non-Executive Director	10-15	0	0	0	0	0	10-15
Christine Fearn, Non-Executive Director (to 30 <sup>th</sup> September 2023)	5-10	0	0	0	0	0	5-10
Dr. Ian Reckless, Non-Executive Director **	10-15	0	0	0	0	0	10-15
Jenny Belza, Non-Executive Director (from February 2024)	0-5	0	0	0	0	0	0-5
Simon Page, Non-Executive Director (from February 2024)	0-5	0	0	0	0	0	0-5

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Notes

- \* Steve Washbourne, Chief Finance Officer, was employed by University Hospital Birmingham NHSFT until 2nd July, and his salary costs was recharged to the Trust. The salary costs shown represent the full 12-month cost .
- \*\* Dr Ian Reckless was employed by Milton Keynes NHSFT , who recharged the costs of his appointment.
- ^ These Executive Directors are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. This will have a differing impact specific to individual circumstances which are reflected in the calculated Pension Related Benefit adjustment shown above. Negative values are not disclosed in this table but substituted with a zero.

## 2.13 Fair Pay Multiple [subject to audit]

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2024/25 was £175k-180k (2023/24: £185k-190k). This is a reduction between years of 5.3% (2023/24: increase of 8.6%).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of annualised remuneration in 2024/25 was from £13k to £217k (2023/24: £13k to £188k).

Zero employees received remuneration in excess of the highest-paid director in 2024/25 (2023/24: zero).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2024/2025	25th percentile	Median	75th percentile
Salary component of pay	£24,794	£36,483	£46,148
Total pay and benefits excluding pension benefits	£24,794	£36,483	£46,148
Pay and benefits excluding pension: pay ratio for highest paid director	7.16:1	4.87:1	3.85:1

2023/2024	25th percentile	Median	75th percentile
Salary component of pay	£22,816	£34,851	£45,996
Total pay and benefits excluding pension benefits	£22,816	£34,851	£45,996
Pay and benefits excluding pension: pay ratio for highest paid director	8.25:1	5.45:1	4.09:1

Individuals at the lower end of the salary range, include apprentices used by the Trust and individuals performing bank work on an ad-hoc basis.

The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is an increase of 5.59%.

The movement in the median pay ratio compared to the prior year is primarily due to changes in senior leadership remuneration during the period, including temporary uplifts associated with inter-organisational arrangements. There has been no significant structural change in the pay and benefits of the Trust's wider workforce.

## 2.14 Salary and Pension Entitlements of Senior Managers

### a) Pension Benefits 2024-25 [subject to audit]

Name and title	Real increase in pension at age 60	Real increase/ (decrease) in related lump sum at age 60	Total accrued pension at age 60 at 31 March 2024	Total accrued lump sum at age 60 at 31 March 2024	Cash Equivalent Transfer Value at 1 <sup>st</sup> April 2024	Real Increase/ (decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employer's Contribution to Stakeholder Pension
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)				To nearest £100
	£000	£000	£000	£000	£000	£000	£000	
Matthew Hartland, Interim Chief Executive Officer (from 14 <sup>th</sup> October 2024)	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Joanne Williams, Chief Executive Officer (to 6 <sup>th</sup> September 2024 – currently seconded)	2.5-3	0-(2.5)	55-60	135-140	1,106	23	1,232	0
Nicola Brockie – Executive Chief Nurse	0-2.5	(5)-(7.5)	30-35	75-80	649	3	696	0
Matthew Revell, Executive Medical Director	5-7.5	10-12.5	70-75	180-185	1,406	171	1,672	0
Steve Washbourne, Chief Finance Officer	0-2.5	0-(2.5)	55-60	140-145	1,098	49	1,221	0
Marie Peplow, Executive Chief Operating Officer <sup>^</sup>	0-2.5	(2.5)-(5)	65-70	180-185	0	0	0	0
Simon Grainger-Lloyd – Executive Director of Governance and Data Protection Officer (DPO)	0-2.5	0-(2.5)	30-35	70-75	578	39	655	0
Sharon Malhi – Chief People Officer	0-2.5	0	10-15	5-10	155	30	195	0
Rebecca Lloyd – Director of Strategy (from 1 <sup>st</sup> September 2024)	0-2.5	0	15-20	0-5	164	13	198	0

**Note:**

<sup>^</sup> No CETV figure is shown for senior managers who have reached Normal Pension Age. NPA is age 60 in the 1995 Section

## b) Pension Benefits 2023-24 (Subject to Audit)

Name and title	Real increase/ (decrease) in pension at age 60	Real increase/ (decrease) in related lump sum at age 60	Total accrued pension at age 60 at 31 March 2023	Total accrued lump sum at age 60 at 31 March 2023	Cash Equivalent Transfer Value at 1 <sup>st</sup> April 2023	Real Increase/ (decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employer's Contribution to Stakeholder Pension
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)				To nearest £100
	£000	£000	£000	£000	£000	£000	£000	
Joanne Williams, Chief Executive Officer*	0	42.5-45	50-55	130-135	809	215	1,106	0
Nicola Brockie – Executive Chief Nurse *	5-7.5	35-37.5	30-35	75-80	346	268	649	0
Matthew Revell, Executive Medical Director*	0	27.5-30	55-60	160-165	1,176	112	1,406	0
Steve Washbourne, Chief Finance Officer*	0	32.5-35	50-55	135-140	834	180	1,098	0
Marie Peplow, Executive Chief Operating Officer*^	0	5-7.5	60-65	170-175	1,367	0	0	0
Simon Grainger-Lloyd – Director of Governance and Data Protection Officer (DPO)*	0-2.5	30-32.5	25-30	65-70	373	166	578	0
Sharon Malhi – Chief People Officer	2-2.5	0	10-15	5-10	94	51	155	0

**Note:**

\* These Executive Directors are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 scheme on 1 October 2023. This will have a differing impact specific to individual circumstances which are reflected in the above table. Negative values are not disclosed in this table but substituted with a zero.

^ No CETV figure is shown for senior managers who have reached Normal Pension Age. NPA is age 60 in the 1995 Section

## 2.15 Total Pension Entitlement

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The Real Increases in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee and uses common market valuation factors for the start and end of the period.

The impact of the McCloud remedy has been incorporated into NHS Pension Scheme valuations where applicable. However, due to the ongoing implementation timeline and member-specific calculations, some CETVs disclosed may not yet reflect final adjusted benefits.

## 2.16 Directors and Governors in office and expense claims

The total number of Directors and Governors in office in the financial year, and their expense claims, has been shown below:

	2024-25	2023-24
Number of Directors in office*	16	13
Number of Directors with expense claims	6	6
Financial value of expense claims made by Directors (£00)	69	2
Number of Governors in office	14	14
Number of Governors with expense claims	-	-
Financial value of expense claims made by Governors (£00)	-	-

\* Voting members only



Matthew Hartland  
Chief Executive  
25 June 2025

## Section 3: Staff Report

### 3.1 Analysis of Average Staff Numbers

Average number of employees (WTE basis)	Group			
	2024/25			2023/24
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	135	26	162	141
Administration and estates	473	49	522	496
Healthcare assistants and other support staff	201	21	222	227
Nursing, midwifery and health visiting staff	305	30	336	321
Scientific, therapeutic and technical staff	149	17	166	154
Healthcare science staff	-	-	-	-
Total average numbers	1,264	143	1,407	1,339
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	-	-

### 3.2 Employee expenses and numbers – Group

	2024/25			2023/24
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	62,937	1,145	64,082	58,100
Social security costs	6,714	-	6,714	5,723
Apprenticeship levy	303	-	303	268
Employer's contributions to NHS pension scheme	7,499	-	12,423	9,019
Pension cost - other	4,937	-	12	20
Temporary staff	-	2,250	2,250	5,858
NHS charitable funds staff	236	-	236	84
<b>Total gross staff costs</b>	<b>82,625</b>	<b>3,395</b>	<b>86,020</b>	<b>79,072</b>
Recoveries in respect of seconded staff	-	-	-	-
<b>Total staff costs</b>	<b>82,625</b>	<b>3,395</b>	<b>86,020</b>	<b>78,967</b>
<b>Of which</b>				
Costs capitalised as part of assets	-	-	-	-

### 3.3 Employee expenses

The total Employer Pension contribution payable for the period to 31 March 2025 is £7,499k (31 March 2024 - £6,100k).

### 3.4 Staff breakdown by gender

Gender and Role (by headcount) as at 31<sup>st</sup> March 2025 (Not including bank staff)

Title	Female	Male	Total
Non-Executive Directors	5	4	9
Executive Directors	4	3	7
Other Employees	1050	462	1512
<b>Total</b>	<b>1059</b>	<b>469</b>	<b>1528*</b>

\* number does not reconcile to the figure in 3.1 as this represents staff numbers at a point in time, rather than average staff numbers across the year

### 3.5 Staff breakdown by disability

Disability and Role (by headcount) as at 31<sup>st</sup> March 2025 (Not including bank staff)

Title	Yes	No	Not Stated	Total
Non-Executive Directors	-	8	1	9
Executive Directors	2	5	-	7
Other Employees	132	1338	42	1512
<b>Total</b>	<b>134</b>	<b>1351</b>	<b>43</b>	<b>1528</b>

### 3.6 Staff breakdown by ethnicity

Ethnicity and Role (by headcount) as at 31<sup>st</sup> March 2025 (Not including bank staff)

Title	BME	White	Not Stated	Total
Non-Executive Director	3	6	-	9
Executive Director	1	6	-	7
Other Employees	517	988	7	1512
<b>Total</b>	<b>521</b>	<b>1,000</b>	<b>7</b>	<b>1528</b>

### 3.7 Staff breakdown by sexual orientation

Sexual Orientation and Role (by headcount) as at 31<sup>st</sup> March 2025 (Not including bank staff)

Title	Heterosexual or Straight	Bisexual	Gay or Lesbian	Other Sexual Orientation Not Listed	Undecided	Not Stated	Total
Non-Executive Director	6	-	-	-	-	3	9
Executive Director	6	-	1	-	-	-	7

Other Employees	1335	16	17	3	4	20	1512
Total	1346	16	18	3	4	20	1526

### 3.8 Sickness Absence

Details of staff sickness absence data can be found via NHS digital publication services on 'NHS Sickness Absence Rates' [NHS Sickness Absence Rates - NHS Digital](#)<sup>1</sup>

### 3.9 Staff Policies and Actions applied during the financial year

#### 3.9.1 Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities

The Trust is recognised as a 'Disability Confident Committed Employer' through the Government's Disability Confident Scheme which supports employers to make the most of the skills, knowledge and talents that disabled people can bring to the workplace. The Trust has achieved Level 3 of the scheme - 'Disability Confident Leader.' This means that the Trust actively encourages applications from disabled individuals in accordance with the Equality Act 2010. The Leader status also means that the Trust is asked to advise and support other organisations completing their accreditation. As an organisation we are committed to attracting, employing, retaining, and developing the abilities of disabled staff and this is reflected in the Trust's Recruitment and Selection Policy which is supported by the ABLE network.

The Trust is committed to making necessary adjustments before, during and after the recruitment process. Candidates who have declared a disability through the application process only need to meet the essential criteria of the role to be guaranteed an interview.

Managers ensure that all adverts, job descriptions and person specifications provided to the Recruitment Team do not include statements which could be deemed discriminatory. Reasonable adjustments will also be made to support candidates in the interview process.

In addition, on each interview panel candidates are asked an inclusion question as part of key topics covered.

#### 3.9.2 Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period

The Trust is committed to supporting staff to remain in work. In addition to a robust Sickness Absence Policy which promotes support for individuals who become disabled during their employment, managers also conduct regular risk assessments with all staff which ensure that those individuals, particularly those who may be most vulnerable due to disability are not adversely affected during the course of their duties and to ensure that the appropriate interventions are in place to support individuals to remain at work. The Trust's policy ensures that NHS guidance, advice and necessary training is provided to managers on the application of the policy.

The Trust recognises that staff with a disability may have unintended increased levels of absence therefore time off for treatment or rehabilitation may be provided as a reasonable adjustment and flexibility is at the heart of the approach that managers are encouraged to take. The Trust's Human Resources team works closely with the Trust's Health and Safety Adviser to ensure that reasonable adjustments for staff are considered in a holistic manner by all experts who may be able to support the individual.

To further support and promote this, the ABLE network has created a reasonable Adjustments Health Passport to assist staff who find it difficult to share important information regarding their disability or health condition. It has been devised to share with Line Managers (or others) to help them better understand and support your wellbeing needs and to mitigate the necessity of having repeated conversations.

Managers are required to undertake regular health and wellbeing conversations with all staff with the aim of proactively understanding how an individual may be better supported. The Trust endeavours to ensure a preventative and supportive approach to support our disabled colleagues.

The Trust also has a Stress and Health and Wellbeing Policy which has an emphasis on the Wellbeing of employees. It endeavours to support employees to address any stress related issues both within the home and the workplace and provides guidance around how to undertake stress risk assessments, in order for appropriate actions to be taken. It also offers signposting and support for managers and their colleagues.

All staff have access to an Employee Assistance Programme, Staff Counselling and Occupational Health support as well as mental health and manual handling training. During this financial year, staff have been able to self-refer to counselling. All staff receive regular updates on wellbeing initiatives carried out across the Trust in different formats. Wellbeing conversation training is available for all managers and for colleagues who have staff support responsibilities.

### 3.9.3 Informing and consulting with our staff

The Trust had achieved 'Thrive at Work' Foundation and Bronze and Silver Awards accredited by West Midlands Combined Authority (WMCA). The awards and silver report highlighted the Health and Wellbeing work across the Trust in all areas. This report helps us to concentrate on any gaps we may have.

The Trust is committed to the supporting physical and psychological wellbeing of all its staff and a number of staff members have been trained in psychological first aid training.

The Trust has in place a range of communication channels, in order to provide employees with relevant information in a timely manner. These include regular daily composite e-mails via e-bulletins, a weekly e-mail update from the Chief Executive, a monthly team brief and staff intranet. There are TV screens and noticeboards around the Trust that are used to share key information with staff. There is also a new intranet site to improve access to information for staff members. The Trust also has increased its social media presence, recognising the shift in how people communicate and key updates, access to opportunities and general information is also shared via these means. There is also a number of wellbeing areas at the Trust which are confidential space where staff can also access wellbeing information. These include a wellbeing room, outdoor wellbeing dome and outdoor seating.

The Trust continues to enhance its performance and appraisal policies and practices, both of which are key to our staff understanding how their role contributes to the performance of the Trust. In addition, all staff are encouraged to participate in the Trust's Annual Business Planning process.

The monthly Team Brief has regularly contained detail around the Trust's financial performance which is cascaded throughout the Trust by managers and is also available on the intranet and an open invitation to all staff every month.

The Trust holds a fortnightly informal meeting where HR and staff side discuss employee relations issues.

The Joint Local Negotiating Committee meets quarterly with local and regional medical representatives to discuss the strategic overview for the medical workforce, clinical excellence awards, recruitment and junior doctors.

The Trust Consultative Committee (TCC) meets bi-monthly to discuss workforce issues related to non-medical employees of the Trust and is attended by local and regional staff side colleagues and the Trust's Executive Team. Changes to policy and terms and conditions are also consulted at this forum.

The Trust's Staff Side Chair is an active and valued member of the Trust's People and OD Group which is also attended by a range of managers from across the Trust to help shape and engage with the Trust's workforce related matters and development initiatives.

The Trust has several staff networks and forums where staff can share their views and ideas on 'how it feels to work at the Trust'. These sessions are held face to face and online. Staff also have the opportunity to feedback on ideas through suggestions boxes, and the Trust has recently introduced QI huddles for teams to work together on innovation and continuous improvement.

### 3.9.4 Staff Turnover

Staff turnover for the Trust is as reported in the NHS Workforce statistics which can be found on the NHS Digital Website – NHS Workforce Statistics.

### 3.9.5 Inclusion and Diversity

The Trust is committed to creating an inclusive culture where individuals feel and report a sense of belonging and where each person can bring their whole, authentic self to work without the fear of discrimination. This is mirrored in our approach as a provider of specialist orthopaedic services. We endeavour to ensure that equality, diversity and inclusion are at the centre of our roles as a provider of healthcare services but also as an employer.

The Trust's Inclusion Strategy has key objectives to create a truly inclusive environment at the ROH which in turn will improve the patient, colleague and visitor experience through:

- Tackling and removing all forms of discrimination, in order to promote equality for all;
- Creating an inclusive and healthy ROH culture through Trust values;
- Ensuring our Leaders and Managers role model in a compassionate and inclusive way;

- Giving colleagues a voice to speak up and ask for access to opportunities; and
- Being recognised as a Top Inclusive Employer externally through best practice approach.

We continue to work with our existing staff networks (see further detail in Section 3.23) to promote inclusive cultures at ROH. The first network, the Equality and Diversity network, continues to raise awareness on key topics around Inclusion. The ABLE network is well established and has run a campaign to promote wellbeing through the roll out of “reasonable adjustments health passports”. The LGBTQ+ (BeMyself) network continues to provide a safe space for the support of its members. The Multi Minority Ethnic Group (MMEG) has new leadership and is focussed on expanding membership and access, while continuing to offer a support for ethnic minority staff, particularly through the unrest in the summer of 2024. The Mankind network also has a new Chair and is focussed on expanding membership through the raising of awareness on men’s health issues. The Women’s network continues to support work to close the Gender Pay Gap and address other workplace issues affecting women

The Trust has been ranked in the Top 50 Inclusive Companies index, reaching number 8 in top 50 list in 2025. This shows the continuous commitment in creating an inclusive culture where everybody can thrive. The Trust believes that the rich mix of culture is worth celebrating because we want our team to bring their authentic selves to work. Authenticity means being true to who you are, being true to where you come from and what you believe.

The Staff Experience and Organisational Development (SE&OD) Committee receives a regular workforce report detailing the diversity profile of the Trust and this oversight will ensure that actions are taken pro-actively to ensure that the Trust is diverse in its composition. At each committee meeting a staff member will come and talk to attendees about their experience of working at the Trust.

Any actions from the Workforce Race Equality Standard (WRES) and Workforce Disability, Equality Standard WDES standards, Gender Pay gap action plan EDI Improvement plan and Equality Delivery System are aligned to the overview Inclusion agenda.

### 3.10 Occupational Health and Health and Safety Performance

Progress continues to be made to ensure the Trust, so far as is reasonably practicable, complies with the ‘Workplace Health and Safety Standards’ developed by the NHS Staff Council’s ‘Health, Safety and Wellbeing Group’. The Health and Safety Executive (HSE) is a key member of this Group.

The standards pull together legal requirements and guidance to help healthcare organisations comply with goal-setting legislation. They provide practical pointers and signposting for meeting appropriate standards in key areas of workforce health and safety. The standards were updated in 2022.

Standards are aimed at directors and managers with health and safety responsibilities, health and safety professionals and trade union safety representatives. The standards ensure individual healthcare providers have adequate arrangements in place i.e. policies/procedures/training/systems for monitoring effectiveness etc.

The Trust are re-launching an annual Health and Safety Audit programme over 2025/2026 which aims to cover all departments within the Trust and provide enhanced assurance around compliance with the policies and procedures. Actions will be locally owned and managed by department leads and their teams, with advice and guidance from the Trust’s health and safety advisor and other specialists, where appropriate. The results of the audits will be presented and discussed at quarterly health and safety group meetings.

#### Policies and Procedures

A suite of Trust policies and procedures are in place and meet the guidance published in the Workplace Standards.

The Trust’s Health and Safety Policy is currently under review. Reviews and updates have been undertaken for the following policies:

- Sharps
- Violence, Aggression and Abuse
- Contractors (Control and Management) – new policy
- Work Equipment – new policy

#### Central Alerting System (CAS) Alerts

The ROH is a recipient of patient safety alerts issued via the Central Alerting System (CAS). The Trust has a robust governance structure for the management of patient safety alerts. The Trust’s Health and Safety Adviser acts as the Central Alerting System Liaison Officer (CASLO). The CASLO is responsible for monitoring the CAS system and the dissemination of CAS alerts to the Medical Device Safety Officer for review. The MDSO will nominate a subject matter expert for each alert who is responsible for undertaking any ‘actions required’.

The CAS system is continuously updated evidencing the progress for each alert until all actions required have been completed. Only then will the MDSO give authority to close each alert. Patient Safety Alerts are overseen by the Executive team. During the 2024/25 reporting period, the Trust received a total of 13 patient safety alerts; all of these met the timeframe for completion.

One outstanding alert NatPSA/2024/002/NHSPS (issued in Jan 2024), was due for completion 31<sup>st</sup> January 2025 and was closed on 3<sup>rd</sup> March 2025.

One alert received in 2023 remains open pending completion at time of writing this report – NatPSA/2023/010/MHRA (Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls). Further work is continuing to ensure all actions to close this alert are completed.

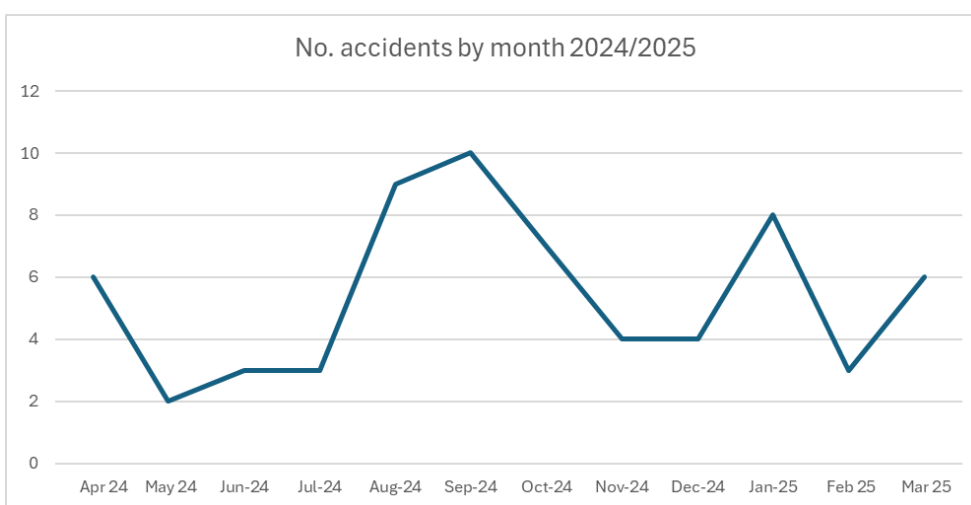
#### CAS Alerts 2024/25

Reference	Alert Title	Response	Deadline
NatPSA/2025/001/DHSC	Discontinuation of Promixin (colistimethate) 1-million unit powder for nebuliser solution unit dose vials	Assessed – not relevant to organisation's services	30 Apr 25
NatPSA/2024/013/DHSC	Shortage of Pancreatic enzyme replacement therapy (PERT) – Additional actions	Assessed – not relevant to organisation's services	31 Jan 25
CEM/CMO/2024/003	Influenza season 2024/25 – use of antiviral medicines	Response not required	n/a
NatPSA/2024/012/DHSC	Shortage of Molybdenum-99/Technetium99m generators	Assessed – not relevant to organisation's services	08 Nov 24
NatPSA/2024/011/DHSC	UPDATE: Discontinuation of Kay-Cee-L (potassium chloride 375mg/ml) (potassium chloride 5mmol/5ml) syrup	Action completed	31 Oct 24
NatPSA/2024/010/NHSPS	Risk of oxytocin overdose during labour and childbirth	Assessed – not relevant to organisation's services	31 Mar 25
NatPSA/2024/009/DHSC	Shortage of Human Albumin 4.5% and 5% dose vials	Action completed	07 Aug 24
NatPSA/2024/008/DHSC	Shortage of Kay-Cee-L (potassium chloride 375mg/5ml) (potassium chloride 5mmol/5ml) syrup	Action completed	12 Aug 24
NatPSA/2024/007/DHSC	Shortage of Pancreatic enzyme replacement therapy (PERT)	Assessed – not relevant to organisation's services	10 Jun 24
NatPSA/2024/006/DHSC	Shortage of Orencia ClickJect (abatacept) 125mg/1ml solution for injection pre-filled pens	Assessed – not relevant to organisation's services	06 Jun 24
NatPSA/2024/005/MVA	Shortage of Erelzi (etanercept) 50mg solution for injection in pre-filled pen	Assessed – not relevant to organisation's services	10 May 24

Reference	Alert Title	Response	Deadline
CEM/CMO/2024/002	Influenza season 2023/24: ending the prescribing and supply of antiviral medicines in primary care	Response not required	n/a
NatPSA/2024/004/MHRA	Reducing risks for transfusion-associated circulatory overload	Action completed	04 Oct 24

**Number of Accidents by Category. 1 Apr 2024 - 31 Mar 2025. (Employees/Visitors/Contractors)**

Accident data is reported via the Trusts’ online incident reporting system, Ulysses. Trends are monitored to assess health and safety performance and to advise on any specific risk patterns. Accident figures are broadly comparable with previous years; categories continuing to show the highest number of work-related accidents are Manual Handling, Sharps, Slips Trips and Falls and Impact injuries.



Accident Category	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Manual Handling Injuries	0	0	0	0	0	4	1	0	0	2	1	1
Burns / Scalds	0	0	0	0	0	0	0	0	0	0	0	0
Contact with hazardous substances (COSHH)	0	0	0	0	0	0	0	0	1	1	0	0
Road traffic accident/ incident	0	0	0	0	0	0	0	0	0	0	0	0
Sharps injuries	0	1	1	1	5	2	1	3	2	4	0	1

Accident Category	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Slips, trips, and falls (staff, visitors & contractors)*	1	0	0	1	2	2	2	1	0	2	2	3
Impact Injury (with static or moving object)	5	1	2	1	2	2	3	0	1	0	0	3
Electric shock	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total figure for each month</b>	= 6	= 2	= 3	= 3	= 9	= 10	= 7	= 4	= 4	= 8	= 3	= 6

\*excluding falls directly related to medical conditions, limited or poor mobility because of clinical factors, where other causes such as defects in premises have not been a contributing factor.

### Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

It is a statutory legal requirement to report specified injuries, diseases, deaths, and dangerous occurrences to the HSE. During the reporting period five RIDDOR reportable incidents were submitted:

#### RIDDOR Reporting 2024/25

Date of Incident	Summary of incident	Date RIDDOR Report submitted to HSE / Ref
25 August 24	Colleague accidentally dropped papers onto floor. Whilst seated, bent over to pick up papers for her. Chairs suddenly jettisoned away causing fall to floor. Took one day ill health sickness absence before returning to work. Later visited G.P and obtained sick note for 2 weeks ( <b>'over 7-day incapacitation' - RIDDOR reportable</b> ).	9 September 2024 / B18E168831
23rd December 2024	Member of staff working in Outpatients was leaning against open door to patient pods, with their hand on the hinged side. Door was being held open by patient behind. Door was then 'let go' and closed onto little finger of left hand (trapped in hinge cavity). Individual pulled hand away resulting in loss of tip of finger. Attended QE for surgery and required removal of finger bone to first knuckle. <b>Specified injury (partial amputation of finger)</b>	31st December 2024 / F6A1C5148E
2 <sup>nd</sup> January 2025	The staff member was working in Dispensary, sat on their office chair. They stood up and in doing so held the chair in one hand on the seat. The chair rolled away backwards as they went to sit back down, they lost balance and fell landing on the floor (seated). This jarred their lower back and wrist, causing some pain. Subsequently signed off work by GP <b>('over 7-day incapacitation' – RIDDOR reportable)</b>	15 <sup>th</sup> January 2025 / 13296177FB
27 <sup>th</sup> February 2025	The staff member (Senior Operating Department Practitioner) was assisting moving a patient from the CT scan bed. In doing so they felt a sudden pain and spasm in their lower back which resulted in severe pain and restricted movement for a number of days following the incident. Signed off work by the GP until the 11 <sup>th</sup> March, at which point they came back to work on a phased return.	12 <sup>th</sup> March 2025 / FB80B88616

	<i>('over 7-day incapacitation' – RIDDOR reportable)</i>	
(Absence from work started) November 2024	Staff in hospital kitchen developed pain in both elbow joints and forearms which gradually worsened. Subsequently diagnosed with Bilateral tennis and bilateral golfer's elbow (Tendonitis) and signed off work, at which point symptoms improved. Manual handling as daily part of job/ no known link with activities outside of the workplace. Referred to Occupational Health who have advised adaptations and adjustments to work activity and a phased return. Returned to work February 2025. <b><i>(Occupational Disease - Tendonitis or tenosynovitis of the hand or forearm: Caused by physically demanding work involving frequent, repetitive movements – RIDDOR reportable)</i></b>	10 <sup>th</sup> March 2025 / CDEA88175D  (Note: Delay in reporting. H&S Advisor first notified by Occupational Health report 13 <sup>th</sup> February 2025)

## Staff training

### Core Mandatory Training Compliance (H&S/Fire)

Staff attendance figures for H&S mandatory training has remained consistently high above 90% across the year (Health and Safety at Work; 92%, Manual Handling Level 1; 94%). This is helped by the fact staff are only required to undertake Health, Safety and Welfare refresher training once every 3 years.

Staff attendance figures for fire training have improved since the previous year – where they were around 75% on average. During '24-25 the figures stand at 80% compliance. However, this still requires improvement. Staff must undertake fire training much more frequently - every 12 months, which contributes to the challenge of meeting compliance goals. E-learning is available for this module to help with accessibility for staff. Learning and Development will continue to work with Estates team (who oversee fire management) with the aim of organising additional training opportunities over the coming year, to achieve the target of at least 90% compliance.

### Additional training

For the reporting period 1 Apr 2024 -31 Mar 2025, the following H&S training sessions were delivered:

- X12 Mandatory training sessions: 3 Apr, 1 May, 5 Jun, 3 Jul, 14 Aug, 4 Sept, 2 Oct, 6 Nov, 4 Dec, 8 Jan, 12 Feb and 5 Mar.
- X3 HCA training sessions: 9 July '24, 8 Oct '24 and 14 Jan 25.
- x1 Stress Awareness Training for AHPs: 25 Apr '24.
- x3 COSHH training sessions: Sept '24, 19 Feb '25 and 11 Mar '25.

One of the key objectives for 2025 / 2026 is to review and enhance the in-house training offering to staff. The first step in this process has been development of a one day 'Health and Safety for Managers' module (classroom delivery) as part of the new 'Me as a Manager' training programme launched at the Trust. The first session will be held in April 2025, with four sessions per year.

## 3.11 Information on policies with respect to countering fraud and corruption

The Trust has a Counter Fraud Policy which sets the framework for fraud and corruption prevention and action. The Local Counter Fraud Specialist remains active in the Trust in policy development, staff education and provision of reactive support.

## 3.12 Off-payroll engagements: Trust policy

The Trust is required as part of this report to disclose its policy in relation to the engagement of individuals via off-payroll arrangements. At present the Trust does not have a specific policy in relation to the circumstances in which off-payroll engagements would be utilised. However, these would always be procured via the Trust's normal procurement procedures with value for money being considered.

The Trust does have a policy in relation to the management of these arrangements once these are in place. The Trust monitors engagements which are more than £245 per day and are expected to last at least six months. Individuals who fall into this category are required to provide assurance to the Trust that the income they receive is properly accounted for in relation to tax. Contracts for these individuals include a clause which states that this information must be provided when requested by the Trust; failure to do so

could result in the contract being terminated. Where information is not provided the Trust notifies HMRC.

To date no contracts have been ended or notified to HMRC due to the failure to provide the required assurance to the Trust.

### 3.13 Highly-paid off-payroll worker engagements as at 31st March 2025 earning £245 a day or greater

No. of existing engagements as of 31 March 2025	0
Of which...	
No. that have existed for less than one year at time of reporting	0
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for between four and five years at time of reporting	0

### 3.14 Highly-paid off-payroll worker engagements as at 31<sup>st</sup> March 2024 earning £245 a day or greater

No. of existing engagements as of 31 March 2024	0
Of which...	
No. that have existed for less than one year at time of reporting	0
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for between four and five years at time of reporting	0

### 3.15 All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater

No. of off-payroll workers engaged during the year ended 31 March 2025	0
Of which:	
Not subject to off-payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	0
Subject to off-payroll legislation and determined as out-of-scope of IR35*	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

\*A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

### 3.16 All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2024 earning £245 per day or greater

No. of off-payroll workers engaged during the year ended 31 March 2024	0
Of which:	
Not subject to off-payroll legislation*	0

Subject to off-payroll legislation and determined as in-scope of IR35*	0
Subject to off-payroll legislation and determined as out-of-scope of IR35*	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

\*A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

### 3.17 Off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

No. of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "Board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	18

### 3.18 Off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024

No. of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "Board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	19

### 3.19 Exit packages

Exit package cost band (including any special payment element)	2024/25			2023/24		
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	0	0	0	0	0
£10,000-£25,000	0	0	0	0	0	0
£25,001-£50,000	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0
£100,001-£150,000	0	0	0	0	0	0
£150,001-£200,000	0	0	0	0	0	0
<b>Total number of exit packages by type</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total resource expense (£'000)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

This element of the annual report has been audited

### 3.20 Retirements due to ill health

During the year to 31 March 2025 there were no early retirements from the Trust agreed on the grounds of ill-health (31 March 2024, nil).

### 3.21 Gender pay gap reporting

The Trust's information on gender pay reporting can be accessed on the hospital's internet site at: [PowerPoint Presentation](#)

National information and guidance about gender pay reporting can also be accessed on the Cabinet Office website at: <https://gender-pay-gap.service.gov.uk>

### 3.22 Staff Survey

The Trust continues to look at different ways to progress in relation to its approach to staff engagement and considers effective staff engagement being core to delivering high quality outcomes for our patients and in supporting our community.

The Trust continues to use different methods to engage with staff including virtual meetings, face to face team meeting, information boards, emails and intranet, focus groups, listening sessions, Manager briefings, and Team huddles to ensure that there has been opportunity for two-way feedback.

Non Executive Directors regular visits departments to speak to staff members in addition to Executive 'Chat and Checks' – periodic engagement sessions with teams across the Trust where Executive Directors can engage with people and hear any feedback they may have about working at the Trust and giving staff the opportunity to engage with the Trust Board. The Executive Directors regularly visit staff in their departments with refreshment trolleys to engage with staff and ensure they have the correct information on how to access support and also feedback new ideas.

The Trust's monthly Team brief provides an opportunity for staff to ask questions of the Executive Team on anything they choose to. The content of Team brief is recorded and copy of the information is available to all staff via the intranet after the meeting.

The NHS Staff (NSS) survey is conducted annually. The NHS quarterly Pulse surveys are run three times a year to provide ongoing feedback to complement the NSS survey focussed on the NSS questions on 'Staff Engagement'. From 2022 year, the results are measured against the seven 'People Promise' indicators aligned to the NHS People Strategy. This is shown in the table below.

Hearing the staff voice this year has continued to be embedded through the work of the staff networks that was described in the opening comments by the Chair and Chief Executive. In addition, the Freedom to Speak Up Guardian continues to be supported by the voluntary Freedom to Speak Up champions to ensure that staff wishing to speak up are heard, supported and signposted to the correct help and ad.

### National Staff Survey Results 2024

The completion rate for 2024 was 59%, a marginal decline on the 2023 response rate of 60%, although the actual physical number of staff completing their annual NHS Staff Survey did increase from 793 to 836. Bank staff were included in the survey this year across the NHS (it was the third time Bank Staff were invited to take part at the Trust)

	ROH 2021	ROH 2022	ROH 2023	ROH 2024	Best Benchmark 2024	Average Benchmark 2024
We are compassionate and inclusive	7.6	7.5	7.5	7.4	8.0	7.5
We are recognised and rewarded	6.2	6.0	6.1	6.1	6.7	6.1
We each have a voice that counts	7.1	6.9	6.9	6.8	7.5	7.0
We are safe and healthy	6.4	6.4	6.6	6.5	7.0	6.5
We are always learning	5.6	5.4	5.6	5.7	7.0	5.8
We work flexibly	6.5	6.4	6.5	6.7	6.9	6.6
We are a team	6.9	6.8	6.8	6.8	7.4	6.9
Staff Engagement	7.3	7.1	7.2	7.1	7.7	7.3
Morale	6.2	6.1	6.3	6.3	6.8	6.3

**Themes/observations show:**

- There has been a positive increase to 836 physical responses for staff taking part in completing the survey during a difficult time across the NHS as whole
- The response rate of 59% is higher than the median response rate of 57% within our benchmark sector group of Acute Specialist Trusts, of which there are 13 in total.
- There has been no statistically significant increase or decrease against our 2023 performance, and we remain at or close to the benchmark average across all 9 themes
- There has been an increase across all nine themes including the 7 People Promise themes for bank staff and these results are very positive compared to the sector and wider across the NHS
- Key themes that the Trust will focus on from the data analysis are around Staff Engagement, discrimination on the grounds of ethnicity, Appraisal quality, supporting and developing managers and non-mandatory training development
- Removing discrimination is an area to continue to progress on with the support from staff feedback and staff networks

The Trust engages with staff through extensive promotion of the Staff Survey, online, through physical posters and face to face meetings and walk rounds, supported by Executive Directors and senior managers.

Focus groups are held to share the staff survey results and to gain feedback on the specific actions that are required in relation to the themes that have been identified for improvement. Actions implemented from the previous year are shared with colleagues at the Focus Groups to show staff 'You said, We did'.

Results are shared by each Executive portfolio and cascaded through Divisional and local meetings with action plans being developed accordingly. Enhanced reporting in 2024 has allowed the Trust to report on more teams, giving Divisions greater visibility across a wider number of smaller teams. This will facilitate more impactful targeted local team specific action plans.

Progress with regards to the organisational action plan will be monitored through the Trust Board and Executive portfolio action plans, the Trust's Staff Experience & Organisational Development Committee in addition to local monitoring through Divisional meetings.

### 3.23 Staff Networks

#### ROH Networks – Staff Voice

The Trust has a growing number of networks run by colleagues to promote the voice of our diverse staff groups. The Trust recognises the strength of supporting our network groups. Equality and Diversity was the first network formed in November 2018, with the remit of raising awareness and promoting Inclusion across the Trust. Following on from the success of the E&D Network, other diverse networks have formed, as shown below. These networks have their own identity and focus and are aligned to the overall Inclusion agenda. The ambition is for the diversity of staff voices to be increased over the coming years. The following networks have clear direction with the overarching aims to provide support, awareness, education, and positive action. All the networks have Chairs or Co-ordinators and sponsors from the ROH Executive Director Team.

#### Equality & Diversity Network (E&D Network)

The Equality & Diversity Network was set up to create the opportunity for employees to discuss matters surrounding diversity, inclusion and to raise awareness within the Trust. The network's focus is increasing around all aspects of equality, diversity and inclusion in the workplace in their broadest sense.



#### Multi Minority Ethnic Group (MMEG)

Multi Minority Ethnic Group (MMEG) was set up in summer 2020 following a series of listening sessions with colleagues at the Trust and formed following the Black Lives Matter Movement. A new Chair and Deputy Chair were appointed in 2024, and the group has focused on expanded participation whilst providing a space for colleagues to talk about issues important to staff from ethnic minority backgrounds with an aim of creating positive change. This was particularly the case in the summer of 2024, in response to the racial unrest, providing a forum for staff to share their experiences and safety concerns with the Trust. Any member of ROH staff, including allies, are welcome to attend meetings and get involved.



**ABLE Network**

The Disability Network aims to promote and celebrate the diversity of our Disabled staff, patients, and allies, and support those with caring responsibilities. A key element of the network is to engage and educate staff around the different disabilities that our colleagues live with. Including those who may have invisible disabilities, such as mental health conditions, or long-term conditions following on from an illness. In 2024 they pioneered the launch of the Reasonable Adjustments Health Passport, designed to make it easier for staff to share important information regarding their disability or health condition with their Line Managers and others, to enable them to better understand and support the staff’s wellbeing needs.



**LGBTQ+ Network (Be Myself)**

BeMyself, The Trust’s LGBTQIA+ Network, is an inclusive and open group of colleagues. The group provides a safe space for members of staff to come together and celebrate diversity and inclusion, and to discuss any concerns they may around the representation of LGBTQ+ staff in the Trust. They welcome allies and celebrate the diversity of the group.



**Menopause Support Network**

In July 2020, a Menopause Support Group was set up; the group offers peer to peer support and has been a great opportunity for colleagues to be open and discuss how they are feeling and also share any support. The group continues to offer guidance, signposting and support for all our colleagues around the menopause. We have two Menopause Champions who help to support colleagues and teams. LTH



**Mankind Network**

The ManKind Network was set up in 2022 and in 2024 a new Chair was appointed to continue the work of supporting and promoting and raising awareness of men’s health and wellbeing as well as promoting the networks and increasing participation.



**Women’s Network**

The network was started at the end of 2022 and initial work included highlighting the career paths of senior leaders as well as raising awareness of important health matters with support from other networks. The network will also support the work to progress a reduction in the gender pay gap and to promote career progression. In 2024 the network has continued to raise awareness on issues pertinent to women through speaker events.

**3.24 Trade Union Facility Time**

**Table 1: Relevant union officials**

The total number of employees who were relevant union officials during the relevant period was as below;

<i>Number of employees who were relevant union officials during the relevant period</i>	<i>Full-time equivalent employee number</i>
3*	1309

\*There is a fourth staff side representative who has been training but is not currently active undertaking facility time.

**Table 2: Percentage of time spent on facility time**

<i>Percentage of time</i>	<i>Number of employees</i>
0%	0
1-50%	2
51%-99%	1
100%	0

**Table 3: Percentage of pay bill spent on facility time**

	<i>Figures</i>
Total cost of facility time	£34,666
Total pay bill	£80.9M
% of the total pay bill spent on facility time (total cost of facility time ÷ total pay bill) x 100	0.23%

**Table 4 Paid trade union activities**

<i>Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: 50%</i>
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### 3.25 Expenditure on consultancy

Consultancy spend for the year was £215k (2023/24, £152k) which included spend on a review of clinical coding and IT consultancy.

## Section 4: The work of the Council of Governors 2024/25

### 4.1 Structure and Members

As a Foundation Trust, the Royal Orthopaedic Hospital has a Council of Governors which helps ensure its key stakeholders - patients, members of the public, staff and partner organisations - all have a say in shaping our local health services. Our Governors act as a direct link between the Trust, local communities and staff and engage with our members to gather feedback and views to ensure their voice is heard.

The Governors play an important role in making the Royal Orthopaedic Hospital publicly accountable for the services it provides and bring valuable perspectives and contributions to our activities. In addition, they help set the strategic direction of the Trust.

Key aspects of the Governors' role include:

- Appointing (or removing) the Trust's Chair and Non-Executive Directors
- Approving the appointment of the Trust's Chief Executive
- Appointing the Trust's external auditors
- Agreeing salaries of Non-Executive Directors and the Chair
- Receiving the annual report and accounts
- Advising the Board and representing members' views about the strategic direction
- Helping the Trust to recruit members
- Contributing thoughts, views and opinions at Council of Governors meetings
- Holding the Non-Executive Directors to account for the performance of the Trust Board.

At the Royal Orthopaedic Hospital, The Council of Governors comprises nineteen members, ten of which are elected to represent public constituencies, four members are elected as staff representatives, and five members are appointed from key local stakeholders and partners.

Governors are elected or appointed by constituency members and during the year. In accordance with the Constitution, all the Trust's Public and Staff Governors are elected through a formal election process and appointed Governors are nominated by their respective organisations.

Brian Toner is the Royal Orthopaedic Hospital's Lead Governor (but during the year there was no cause to exercise the role in regard to dialogue with NHS Improvement regarding the performance of the Non-Executive Directors).

### 4.2 Doing its job – as a whole Council

During the year, the Council of Governors continued to work with the Board to provide input to some of the Trust's key decision-making.

### 4.3 Governor Representation on Trust Committees/Groups/walkabouts

The Council of Governors is able to nominate members to attend Trust advisory groups and committees as observers. They are then able to report back directly to the Council on work being carried out by the Trust and how the Non-Executives are seeking assurance on delivery.

During the year, members of the Council attended as observers at the Patient Experience & Engagement Forum

The governors are also invited to join the quality assurance walkabouts and will be again invited to join these as the schedule becomes embedded through 2025/26.

The governors are also formally invited to join the public Board meetings twice yearly and the Lead Governor has a standing invite to each session of the Board. In this way, the Council actively engages in the work of the Trust, assesses the work of the Board and observes the work of the Chair in a context other than as Chair of the Council of Governors.

There were also a number of Governor 'walk around' sessions undertaken around non-clinical areas of the Trust where Governors

were able to meet with staff to explain their role and seek any views or issues that may be worth escalating to the wider Council of Governors.

Work has continued to link the ROH governors and the Birmingham and Solihull ICB. A lead governors forum has been established at which lead governors from organisations represented in the Integrated Care System attend and discuss topics of mutual interest. All governors are also invited to specific workshops at which key members of the ICB provide updates on the work across the system and the strategic plans that have been developed. The outputs of these sessions are reported back to the Council of Governors each time it meets.

#### **4.4 Council of Governors Nominations and Remuneration Committee**

The Nominations and Remuneration Committee comprises four governors and is chaired by Simone Jordan, one of the Trust's Non-executive Directors. The Committee decides the remuneration, allowances and other terms and conditions for the Chair and Non-Executive Directors. The Director of Governance and Data Protection Officer (DPO) provides support to the Committee.

#### **4.5 Contacting the Governors**

The Governors can be contacted through the Director of Governance and Data Protection Officer (DPO), the Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Northfield, Birmingham, B31 2AP.

#### **4.6 Governor Constituencies**

Members of the public who are members of the Trust are automatically placed into a constituency based on their postcode. Members are able to put themselves forward to become a Governor or vote for a Governor in their registered constituency.

Staff membership is open to those with a permanent or twelve-month fixed term employment contract with the Trust. Staff members are able stand as a Governor or vote for a Governor in their registered class. At the Royal Orthopaedic Hospital there are two classes of staff governor: clinical and non-clinical.

#### **4.7 Public Members**

At the Royal Orthopaedic Hospital, public members of the Trust are drawn from two identified constituencies across England and Wales.

During 2024/25 the Trust had two public constituencies within its public membership:

- Birmingham and Solihull (five seats)
- Rest of England & Wales (five seats)

Eligibility for membership is restricted to those living within the relevant boundary and over sixteen years of age. All election boundaries for public members (including patients) are coterminous with local authority boundaries.

#### **4.8 Staff Members**

The Trust has two constituencies within its staff membership:

- Clinical (two seats)
- Non-clinical (two seats)

#### **4.9 Appointed Governors**

The Trust's Appointed Governors represent local stakeholder organisations. They provide key insight into the health needs of the communities the Trust serves and put forward the views of their organisations at Council of Governors' meetings. The following organisations make nominations to the Council of Governors:

- Birmingham City Council
- Bournville Village Trust
- Northfield Community Partnership
- Birmingham City University

- University of Birmingham
- Aston University

## 4.10 Governor Elections 2024/2025

During the year, the Trust conducted Governor Elections to fill seats that had become vacant in the areas detailed below. The Trust used an external company, Civica Election Services (CES), to oversee the election process with all three sets of elections being conducted using the single transferable electoral system.

At the start of the process an invitation letter from the Chair was sent to all relevant members (where a Governor seat was open for election) to inform them that the election process was starting. The invitation letter included the contact details of the external company facilitating the election process. Ballot papers were then sent to members who in turn voted for the candidate(s) that they wished to be elected to our Council of Governors.

### 4.10.1 Result: Birmingham & Solihull

#### Election 1

An election took place in the Summer of 2024 to fill three seats for Birmingham & Solihull.

The election was run by an external provider, CES, and no valid nominations were received, therefore, three vacancies remain within the constituency of Birmingham and Solihull.

### 4.10.2 Result: Rest of England and Wales

#### Election 2

An election took place in the Summer of 2024 to fill two seats for Rest of England and Wales. The successful candidates being Arthur Hughes and Gareth Yeomans were elected unopposed.

### 4.10.3 Result: Clinical Staff Governor

The above election took place to fill one seat for a Clinical Staff Governor. The successful candidate was Jack Ellis.

#### Election 3

Electorate	922
Total number of votes cast (online only 190)	190
Turnout	20.6%
Invalid votes cast	0
Total valid votes	190

### 4.10.4 Result Non-Clinical Staff Governor

#### Election 4

The above election took place to fill one seat for a Non-Clinical Staff Governor. The successful candidate was Izzy Munford who was elected unopposed. Izzy's first term of office will conclude on 31 October 2027.

## 4.10.5 Elections during 2025/2026

A planned election will be undertaken during the Summer of 2025 when the term of office for Governors in the following constituencies will be complete:

Birmingham and Solihull 4 seats  
Rest of England & Wales 3 seats

## 4.10.6 Process for removal of a governor

The Trust's constitution makes provision for the removal and disqualification of members of the Council of Governors. Governors shall cease to be a member of the Council if:

- They resign in writing to the Company Secretary (Director of Governance);
- They fail to attend at least half of the meetings of the Council of Governors in any financial year, unless the majority of the Council of Governors consider the reasons for the absence to be reasonable;
- They, during their tenure, fail to meet the criteria for being a member of the Council of Governors set out in Annex 6 of the Constitution – 'Additional provisions – Council of Governors'; or
- They fail to undertake training without good reason.

A member of the Council of Governors may be removed from the Council by a resolution approved by not less than two-thirds of the remaining members present and voting at a general meeting of the Council of Governors that they have committed a serious breach of the Trust principles set out in the Constitution; acted in a manner detrimental to the interests of the Trust; and the Council considers that it is not in the best interests of the Trust for them to continue as a member of the Council of Governors.

## 4.11 Governor Profiles

Profiles for each governor, together with their term of office, who served on the Council of Governors during the period 1 April 2024 to 31 March 2025 are provided below:

### 4.11.1 Public Governors:

- **Brian Toner, Lead Governor** - Brian belongs to the Rest of England and Wales constituency. He considers the Trust's paramount goal is to deliver high quality health care, whilst responding to today's economic demand. Having twice been a patient at the Hospital, he had been hugely impressed by the professionalism of the staff and care he received and was happy to become a member and later a Governor, and give something back. Brian believes that quality services are delivered by committed staff, supported by a strong governance foundation, including feedback from service users. Equally, strategic direction needs to be developed through genuine stakeholder engagement and his experience as a patient, his health service background, work with charities and his involvement with the Care Quality Commission will enable him to make a positive contribution as a Governor to the Trust's success and ongoing development.

Brian was re-elected as a public governor in the summer of 2022 and the Council of Governors unanimously agreed to reappoint him as the lead governor for this further term of office. Brian's third term of office finishes on 31 July 2025.

### 4.11.2 Birmingham and Solihull (five seats):

- **Lindsey Hughes** – Lindsey is a past Governor of the ROH and last served on the Board of Governors in 2022. As a previous Governor, Lindsey wanted to continue in helping ensure the Trust focuses on balancing the priorities and challenges it faces today and in the future, whilst safe-guarding its principal purpose of providing high quality health care to the Orthopaedic patient community.

Lindsey recognises this is an exciting time for the hospital whilst it embraces the opportunity to reduce waiting lists both locally and nationally and reducing length of stay. She is passionate that patients receive the best quality care possible.

Lindsey has been a volunteer at the hospital for over 11 years, undertaking patient feedback surveys and hears directly about their experience whilst still in the hospital. Lindsey classes herself as a good listener and is not afraid to raise concerns with the appropriate person or board member.

Lindsey has first-hand experience of the hospital's engagement and support of people who have learning disabilities. Prior to retirement, Lindsey was a Head of Nursing at Birmingham Children's Hospital and this is where she spent her whole nursing career.

Lindsey has a Master's Degree with a Distinction in Health Care Risk Management. She has lived locally for the past 23 years hence why she is involved in a variety of community initiatives. Lindsey is a member of the Phoenix Choir whose predominant aim is to raise funds for local charities. As a carer for her mother, Lindsey is used to negotiating the paths of health and social care. Lindsey's first term of office will come to an end on 31 October 2026.

- **Petro Nicolaidis** - Petro has been a patient with ongoing treatment since January 2010. He is extremely grateful to the hospital for all it has done and continues to do for him, and wanted to contribute back to the hospital. Petro runs a small financial and business consultancy practice locally and serves as a School Governor in a local secondary school. Petro's second term of office came to an end on 31 July 2021 and he was elected for a third and final term of office which ended on 31 August 2024.
- **Rheya Dole** - Rheya Dole was elected unopposed during the Summer of 2022. Rheya's first term of office will come to an end on 31 July 2025.

#### 4.11.3 Rest of England and Wales (five seats including Lead Governor as above)

- **Arthur Hughes** - Arthur's national and international business life has given him experience of listening to both sides of discussions in helping/guiding with solutions. Arthur has lived/worked in Africa, Europe, North America and China working alongside management boards of companies, government departments/ organisations and professional bodies (including the World Health Organisation). Arthur is a former patient of the hospital and former member of Patient and Carers Forum. He wishes to work with the Trust in his Governor role to help the hospital continue its successful progress and to uphold the responsibility of talking to members and sharing their concerns, acting upon them, and reporting back, jointly reviewing the forward plans enabling the Trust to continue to provide excellent services as recognised by the "getting it right first time" recognition. Arthur's second term of office came to an end on 31 August 2024, and he was re-elected for a third and final term of office until 31 October 2027.
- **Mary (Pat) Clarke** - Pat was elected as Governor in August 2021 for a first term of office. Pat is a former Staff Nurse of the Royal Orthopaedic Hospital and retired nurse from the District Nursing Service. She feels her contribution from both areas of the NHS would bring a more holistic view of healthcare on behalf of the members to the Council of Governors. The Pandemic made Pat realise that she would like the opportunity to contribute to the ROH on behalf of the patients, public and members in providing an efficient and amicable feedback to the Council. Pat's term of office came to an end on 31 August 2024.
- **Robert Rowberry** - Rob has been a patient at the Royal Orthopaedic Hospital and commented that he has seen the Trust grow in stature from when the hospital was known as 'The Woodlands'. The growth of the hospital encouraged him to apply to become a Governor. He was honoured to be elected as Public Governor within the Rest of England & Wales Constituency. Rob's first term of office will come to an end on 31 July 2025.
- **Robert Talboys** - Due to the continuing care and attention Rob received as a patient of The Royal Orthopaedic Hospital, Rob applied to become a Governor as a way of repaying the Hospital and staff for the care he received. Rob has been a Governor previously at the Trust.

Rob studied for a BSc degree with the Open University, specialising in Electronics and Design and was an electrical engineer, working mainly in industry. Rob is conversant with budgeting/costing and has a good knowledge of accounting.

Rob wanted to be able to offer his interpersonal skills with fellow Council members to further the future interests of Trust and was elected as Public Governor within the Rest of England & Wales Constituency. Rob's first term of office will come to an end on 31 July 2025.

- **Gareth Yeomans** - Gareth is a professional engineering manager, responsible for daily strategic decisions that effect facilities/infrastructure and people alike, centred around the now and future planning and finances.

Gareth is a family man and having received hip surgery himself, he felt a kinship and wanted to help an amazing organisation with amazing people. Gareth's surgery gave him a unique prospective, on customer care and unity that derives from this.

Gareth wanted to give back something to the community and to the talented individuals working in and around the NHS making them feel valued, safe, informed and involved.

Gareth is an active member of the Reservists at the Royal Engineers, training individuals and believes he has the drive to work with the Trust in achieving the best possible outcome be that for the people and or the facilities associated with them, for now and the future. Gareth was elected for a first term of office which will come to an end on 31 October 2027.

#### 4.11.4 Stakeholder Governors

- **Bournville Village Trust** - David Robinson is the Director of Financial Resources at Bournville Village Trust who own the freehold of the Hospital as the Cadbury family donated the building and land to the people of Birmingham for health purposes. David joined BVT in May 2017 and covers all aspects of Finance and IT for them and its associated managed societies. David's professional membership includes Fellow of the Royal Society of Arts (FRSA) and through his fellowship he contributes to several groups and forums on public policy and supports the Society in their aims to contribute to building a better society. He is also a member of the Charity Finance Group and Charity Group as well as a Member of the Voluntary Organisations Disabilities Group – Finance Director Group. David's second term of office came to an end on 30 April 2024 and was extended for a third term of office until 30 April 2027.
- **Birmingham City Council** - Councillor Jamie Tennant is our representative from Birmingham City Council, Jamie is currently serving a three-year term of office which will come to an end on 31 March 2027.
- **University of Birmingham** - Dr Eliot Marston is our representative from the University of Birmingham. Eliot's role at the University is Deputy Director of Operations – Research & Development. Eliot's first term of office comes to an end on 31 March 2027.
- **Birmingham City University** - Hannah Abbott represents Birmingham City University (BCU) on the Council of Governors. Hannah's current role at BCU is an Associate Professor and Acting Head of School for the School of Health Sciences. Hannah is passionate about the development of the future healthcare workforce and being part of ROH allows her to better understand the issues affecting the hospital. Hannah's professional background is in theatres as an Operating Department Practitioner, and therefore has a keen interest in surgery and particularly patient safety. Hannah's second term of office came to an end on 31 August 2023. Hannah is currently serving a third term of office which will conclude on 31 August 2026.
- **Aston University** – Chris Langley is our representative from Aston University. Chris' role at the University is Deputy Dean of the College of Health and Life Sciences. Chris' first term of office comes to an end on 31 March 2027.
- **Northfield Community Partnership** – Maxine Shanahan has been the Operational Manager at Northfield Community Partnership (a charity helping people and community groups in South Birmingham) since the Summer of 2015. Maxine previously spent thirty years at a Further Education College, starting as a Technician and progressing into teaching and contract compliance work. Maxine's first term of office started on 1 January 2021 and runs for three years initially, after which time the host organisation, in agreement with the Trust, can reappoint Maxine for a further term. Maxine's first term of office as Governor with the Trust came to an end on 31 December 2024.

#### 4.11.5 Clinical Staff Representatives (two seats)

- **Wilson Thomas** – Wilson has been a Consultant in the hospital for over 14 years, working on the floor in the Trust, and has been the lead for medical workforce to improve the overall staff experience. Wilson seeks the privilege to represent the view and needs of the Trust, especially with the challenges of the 10-year NHS forward plan and integration of services within the BSol system.

Wilson would like to share his knowledge and experience and engage with the Board to improved patient care and staff experience. Wilson's first term of office came to an end on 31 August 2024.

- **Petros Mikalef** – Petros was appointed a Clinical Staff Governor in October 2023. Petros has been working at the hospital for the past 5 years and is keen to ensure the organisation continues to thrive in every level.
- **Jack Ellis** – Jack was appointed as Clinical Staff Governor during the Summer of 2024. Jack wanted to represent staff at the ROH and give a voice to anyone who may feel they are unheard and in doing so would like to ensure that the needs of all staff, patients and the community from all backgrounds are regularly addressed.

Jack has worked in the Trust in the Theatres Department since March 2021 and prior to this was in a managerial position for 3½ years at this previous employment. Jack recognises the challenges the NHS are currently facing and believes the ROH could be a leader in these changes, whilst maintaining the needs of all staff and patients throughout. Jack's intention is to be actively committed in ensuring that all Trust policies and decisions are based on evidence with the inclusion of thorough input from staff. Jack's first term of office was scheduled to come to an end on 31 October 2026. However, he resigned as Clinical Staff Governor prior to this date, during this financial year. Plans are in place to fill this vacant seat.

#### 4.11.6 Non-Clinical Staff Representative (two seats)

- **Pete Law** - Pete has worked at the hospital for 5 years in the Communications Team. Pete wanted to become a Staff Governor because he felt it was important for the hospital to be an open and inclusive place for both staff and patients. In his role as Graphics and Media Manager, Pete has worked with a wide cross section of staff, both clinical and non-clinical. He believes he is well placed to represent the staff body to the other governors and exec team.

Pete recognises the importance of ensuring the ROH is an inclusive hospital and that Trust values are upheld. He believes it is vital that staff are able to bring their authentic self to work and be able to work in a place that has their well-being at heart. As a Staff Governor, Pete aims to ensure that the voice of the staff is heard and considered in the decisions that the Trust makes, that integrity is upheld and that the ROH is inclusive to everyone, both staff and patients. Pete's first term of office will come to an end on 31 October 2026.

- **Izzy Munford** – Izzy currently works within the Governance Department of the Trust as a Clinical Governance Facilitator. Within her position as Non-Clinical Staff Governor, Izzy would like to help ensure the Trust continues to meet the highest standards of care and community service.

Izzy's previous experience as a National Employee Forum Representative has equipped her with the skills to effectively be an advocate for staff, championing speaking up, openness, and honesty at all levels.

In her current role Izzy works at the intersection of safety and continuous improvement, gaining a deep understanding of the complexities of our health service. Izzy thoroughly enjoys being able to meet people from across the Trust and gain their valuable insight to promote quality standards and shared learning from incidents and excellence. Izzy is particularly passionate about advocating for the needs of our local community and ensuring that every voice is heard, especially those who are unable to advocate for themselves. Her role demands that she actively listens, asks constructive questions, and works collaboratively. Izzy's first term of office will come to an end on 31 October 2027.

## 4.12 Attendance by Governors at Council of Governor Meetings 2024/25

During the period 1 April 2024 to 31 March 2025 the Council of Governors formally met on five occasions. A record of the attendance by each Governor at the formal meeting is included in the table below:

GOVERNOR/CHAIR	DATE					TOTAL
	24/04/24	31/07/24	18/09/24	20/11/24	16/01/25	
Tim Pile (Ch)	✓	✓	✓	✓	✓	5/5
Brian Toner	✓	✓	✓	✓	✓	5/5
Pat Clarke	A	A				0/2
Arthur Hughes	✓			✓	✓	3/3
Robert Talboys	A	A	✓	A	✓	2/5
Robert Rowberry	✓	✓	✓	✓	✓	5/5
Gareth Yeomans				✓	✓	2/2
Lindsey Hughes	✓	✓	✓	✓	✓	5/5
Rheya Dole	A	✓	A	A	A	1/5
Petros Nicolaides	✓	A				1/2
Pete Law	✓	A	✓	✓	✓	4/5
Wilson Thomas	A	A				0/2
Izzy Munford				✓	✓	2/2
Jack Ellis				✓	✓	2/2
Petros Mikalef	✓	A	✓	A	✓	3/5
Hannah Abbott	A	A	✓	✓	A	2/5
David Robinson	A	✓	A	A	✓	2/5
Maxine Shanahan	A	A	A	A		0/4
Prof Chris Langley	✓	A	✓	A	A	2/5
Dr Eliot Marston	✓	✓	✓	✓	✓	5/5
CLlr Jamie Tennant	✓	✓	A	A	A	2/5

### KEY:

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		

A record of attendance by Board members at the Council of Governor meeting during 2024/25 is provided in the table below:

BOARD MEMBERS	MEETING DATE				
	24/04/24	31/07/24	18/09/24	20/11/24	16/01/25
Simone Jordan	✓	✓	A	✓	✓
Gianjeet Hunjan	✓	✓	✓	✓	✓
Les Williams	✓	✓	✓	A	A
Ayodele Ajose	✓	A	A	A	A
Ian Reckless	A	A	A	✓	A
Jenny Belza	✓	✓	A	✓	A
Simon Page	✓	A	✓	✓	A
Jan Teo		✓	A	A	A
Jo Williams	✓	✓	✓		

Matthew Hartland				✓	✓
Steve Washbourne			✓	✓	✓
Simon Grainger-Lloyd	✓	✓	A	✓	✓
Nicola Brockie	✓			✓	✓
Marie Peplow			✓		
Sharon Malhi	✓				

**KEY:**

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		

The Annual General Meeting was held on 20 November 2024, where attendees were given the option to join virtually or in person.

### 4.13 Council of Governor Meetings

Topics covered at the formal meeting included:

- Chair and Chief Executive’s updates
- Wellbeing and cost of living update
- Overview on the Care Quality Committee (CQC) framework
- Governor re-engagement and upskilling
- Update on the quality assurance walkabouts
- Progress on the work of the Freedom to Speak Up Champions
- Update on the national inpatient survey results
- Progress with governor-sponsored quality priority
- Update on the Electronic Patient Record and Digital Roadmap
- Update on the work of the Board Committees
- Progress with governor elections
- Service presentation on Musculoskeletal Transformation

Executive Directors of the Trust attended meetings to provide updates as follows:

- The Chief Executive attended each Council of Governors meeting during the year to provide updates on key areas, including the ROH’s participation in the work of the Birmingham and Solihull Integrated Care System (ICS).
- The Chief Nurse joined the meeting to present an update on the delivery of the Quality Priorities and to present the recommendation for the governor sponsored priority for the coming year.
- The Director of Finance joined to provide an overview of the annual accounts
- The Director of Governance attended all meetings to present a number of reports on matters such CQC Inspection Framework.

As the overriding role of the Council of Governors is to hold the Chair and Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors, Non-Executive Directors of the Trust regularly attend meetings and provide updates to the Council of Governors on their work and the work of the Board.

### 4.14 Governor Training and Induction

The Trust continually reviews delivery of Governor training and continues to develop in-house Trust-specific training.

At the April 2024 and September 2024 meetings of the Council of Governors, the Director of Governance presented a training and engagement plan as an overview of the support and training available to Governors.

The training plan focussed on a set of workshops across many disciplines of the organisation to help familiarise the governors with the work of the organisation, in addition to some nationally offered training sessions for governors.

There were four new members of the Council of Governors elected and appointed during the year. The current induction process includes a welcome meeting with the Chair, Chief Executive and Director of Governance and an induction booklet setting out the statutory duties of a member of the Council of Governors. The Director of Governance acts as the primary first point of contact for the governors and their training needs. A site tour is also provided for new governors.

#### 4.15 Effectiveness of the Council of Governors

During the year there has not been a formal effectiveness review of the Council of Governors organised.

At the end of each meeting, there is an opportunity to discuss the effectiveness of the Council of Governor meeting and a pre-meet of the governors that started in 2019 will continue throughout the year which allows the governors to talk about matters that may not lend themselves to discussion in the confines of a formal meeting.

#### 4.16 The Council of Governors' Register of Interests

The Register is available for inspection on application to the Trust's Director of Governance, The Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Northfield, Birmingham, B31 2AP.

No member declared a material conflict of interest during the year and all interests were registered and available for inspection.

Members of Council receive no remuneration, but they are entitled to claim expenses at an agreed rate.

#### 4.17 Engaging Our Membership

Events held in 2024 included the Annual General Meeting which members were invited to attend face-to-face or online via Microsoft Teams. Trust members were given the opportunity to ask questions in advance of the AGM.

We actively connected with 22% of members who provide us with an email address and opted-in to regular communication. Throughout 2024 members with an email address have been contacted with new publishes of ROH Life and engagement opportunities.

A significant number of members do not currently receive regular postal communications apart from notification of upcoming elections and voting opportunities.

Our Trust newspaper, ROH Life, is emailed to all Foundation Trust Members upon release once a quarter. The newspaper is also available for the public to receive physically within the hospital. An appeal for new members is included within each edition to enhance our membership.

##### **Member Recruitment**

- A recruitment space for members is dedicated in each ROH Life newspaper.
- Information about signing up to be a Foundation Trust member is included on the digital screens in the Outpatient waiting area. Along with this, we utilise engagement of activities such as SIMS, work experience and where members of the public are invited to conferences / workshops at The Royal Orthopaedic Hospital.
- All staff leavers are sent information regarding Trust membership and are provided with the link to sign up.

Along with the above, the following will be continued in 2025/26

- Information to be shared at sessions/courses where external stakeholders or members of the public are invited.
- Social media promotions to attract an online audience.
- Advertisement section in ROH Life.

In order to support the hospital, we are aware the Trust needs to continue to recruit a broad range of members from a variety of backgrounds, including hard-to-reach areas.

## 4.18 Membership Strategy

The membership engagement strategy and action plan focusses on retention, recruitment and engagement. It aims to give the public, patients and families the opportunity to share their voice in a proactive way.

Any member may contact the Trust's Director of Governance at the Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Birmingham B31 2AP. Tel: 0121 685 4000.

## 4.19 Membership size and movements

The Trust has two membership constituencies as follows:

- Public constituency
- Staff constituency

Public members are drawn from those individuals who are aged 16 or over and:

- Who live in one of the Trust's public constituencies; or
- Who live in the Rest of England constituency

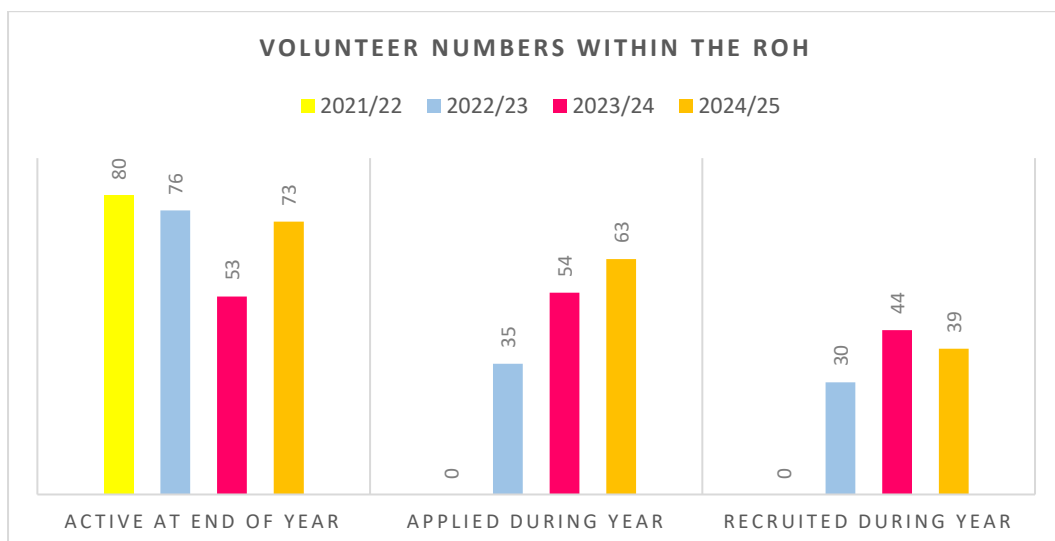
	2024/2025	Forecast 2025/2026
<b>Public constituency</b>		
At year start (April 1)	4,377	4,296
New members	12	20
Members leaving	93 (including deceased)	100
At year end (March 31)	4,296	4,215
<b>Staff constituency</b>		
At year start (April 1)	1432	1479
New members	231	136
Members leaving	184	220
At year end (March 31)	1479	1395

## 4.20 Volunteers

The Royal Orthopaedic Hospital deeply values its volunteers and the incredible impact they have on the community. Their dedication, energy, and compassion make a real difference—not just to patients, but also to families, carers, and hospital staff.

Volunteering enhances patient experiences while supporting key hospital services, from administration and portering to charity work. Many roles involve direct interaction with patients, fostering connection and reassurance, while others contribute to the hospital's essential functions. An exciting new development is the Welcome Desk initiative, where volunteers will become the friendly and supportive first point of contact for visitors, ensuring everyone feels at ease from the moment they arrive.

These roles don't replace the work of paid staff but instead complement patient-centred care, adding an invaluable human touch to the hospital's atmosphere. Volunteering benefits everyone involved, creating a stronger, more compassionate hospital community.



The Royal Orthopaedic Hospital has continued to strengthen its volunteer programme, refining and expanding roles as the service evolves. Insights from previous recruitment efforts have helped create a more stable and committed volunteer workforce across wards and departments, ultimately enhancing the patient experience.

Notably, there has been a decrease in volunteers leaving, with some transitioning into paid employment—including roles within the ROH itself. This demonstrates the programme’s success in fostering both personal and professional growth for its volunteers.

Structured job role advertising and recruitment have provided clarity for applicants and services alike, ensuring consistency while cultivating a sense of purpose and belonging within the Trust.

**Volunteer Promotion and Recognition**

The Royal Orthopaedic Hospital actively promotes its volunteer services across the Trust, with leaflets offering insight into roles and application details and a dedicated page on the Trust website providing further information on opportunities and how to get involved:

To strengthen the volunteer community, the hospital hosts a variety of events throughout the year:

- **Coffee Catch Ups** – an opportunity for volunteers to connect, share experiences, and receive specialist training over coffee and cake.
- **Volunteer celebrations** – including the **June Volunteer Party**, held in line with National Volunteers Week and supported by ROCS, along with the annual **Christmas Party**, both featuring food, games, and plenty of cake!
- **Executive engagement** – hospital leaders participate in these events to recognise volunteers’ contributions and explore ways to enhance the service.



In addition, promotional stands and events throughout the hospital encourage patients, visitors, and families to consider volunteering, highlighting the benefits of giving back.

Recognising volunteers is a priority at ROH. Their generosity, dedication, and kindness enhance patient care and support hospital staff, making a meaningful impact on the whole community. The Trust is incredibly grateful for its volunteer team, whose compassion strengthens the hospital’s community, and they are celebrated and appreciated by all of the teams, wards and departments they work alongside.



## Section 5: Code of Governance and Foundation Trust Reporting Manual Disclosure requirements

### 5.1 Disclosure of Corporate Governance Arrangements

The Royal Orthopaedic Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, last updated in 2023, is based on the principles of the UK Corporate Governance Code issued in 2012.

### 5.2 Statutory Requirements

The Code of Governance contains a number of statutory requirements, with which the Trust is compliant and do not require disclosure statements in the Annual report.

### 5.3 Provisions Requiring a Supporting Explanation

The Code of Governance contains a number of provisions that require the Trust to give a supporting explanation as to whether the Trust is compliant or not. The relevant disclosure statements are detailed below. It also includes some requirements not listed in schedule A to the Code of governance but are required by the FT Annual Reporting Manual.

<b>Code of Governance reference</b>	<b>Summary of requirement</b>	<b>Reference in Annual Report/ Response</b>
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Chair and Chief Executive's summary describes the approach to System working and collaboration. Accountability Report – Section 1.5 Key Issues, Risks and Opportunities
A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Accountability Report - Section 3: Staff Report. Specific sections within the report describe the approach to wellbeing and the analysis of the staff survey which provides an indication of culture.
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so	Accountability Report – Section 1.18 Stakeholder Relations

Code of Governance reference	Summary of requirement	Reference in Annual Report/ Response
	that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	
B 2.6	<p>The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:</p> <ul style="list-style-type: none"> <li>• has been an employee of the trust within the last two years</li> <li>• has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust</li> <li>• has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme</li> <li>• has close family ties with any of the trust's advisers, directors or senior employees</li> <li>• holds cross-directorships or has significant links with other directors through involvement with other companies or bodies</li> <li>• has served on the trust board for more than six years from the date of their first appointment</li> <li>• is an appointed representative of the trust's university medical or dental school.</li> </ul> <p>Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.</p>	Accountability Report - Section 1: Directors' Report
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Accountability Report – Section 1.11 Board and Committee Membership and Attendance
B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	Accountability Report – Section 1.8 Statement of operation of the Board of Directors and Council of Governors

<b>Code of Governance reference</b>	<b>Summary of requirement</b>	<b>Reference in Annual Report/ Response</b>
C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	No External consultants have been engaged in the past year.
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	Section 1.6 Appointment of Chair and Non-Executive Directors A Terms of Reference for the Nominations Committee (Non-Executives) is in place and available for public scrutiny where required
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	Accountability Report – Section 1: Directors' Report
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Accountability Report – Section 1.15 NHS England's well led framework  Accountability Report – Section 8.1 The principal risks to compliance with the NHS Provider Licence (Governance)
C 4.13	<p>The annual report should describe the work of the nominations committee(s), including:</p> <ul style="list-style-type: none"> <li>• the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline</li> <li>• how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition</li> <li>• the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives</li> <li>• the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served</li> <li>• the gender balance of senior management and their direct reports.</li> </ul>	Accountability Report – 1.11.7 Nominations and Remuneration Committee

<b>Code of Governance reference</b>	<b>Summary of requirement</b>	<b>Reference in Annual Report/ Response</b>
C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Accountability Report - Section 1.9 Working with Governors and Members Presentations to the governors on the strategy took place when the new strategy was launched and there has been wider consultation on the Trust's strategy with the wider public, staff and stakeholders. There has also been a consultation exercise undertaken involving governors and the public on the quality priorities for this year. Governors and members also receive ROH Life which provides an opportunity for any comment or questions on the work of the Trust
D 2.4	The annual report should include: <ul style="list-style-type: none"> <li>• the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed</li> <li>• an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans</li> <li>• where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit</li> <li>• an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.</li> </ul>	Accountability Report – Section 1.11.2 Audit Committee Council of Governors also has a statutory duty to approve the appointment of External Audit
D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Accountability Report – Section 7 Statement of the Chief Executive's responsibilities
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Accountability Report – Section 8 Annual Governance Statement
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material	Accountability Report – Section 8 Annual Governance Statement

Code of Governance reference	Summary of requirement	Reference in Annual Report/ Response
	controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	Accountability Report – Section 1.12 Going Concern Statement
E 2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Not applicable – No Executive Directors has been released to serve elsewhere
Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Accountability Report – Section 4.11 Governor Profiles
Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust’s website and in the annual report.	Accountability Report – Section 4.17 Membership Strategy
Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members’ opinions and consultations.	Accountability Report – Section 1.8 Statement of operation of the Board of Directors and Council of Governors
Additional requirement of FT ARM resulting from legislation	<p>If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report.</p> <p>This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012.</p> <p>* Power to require one or more of the directors to attend a governors’ meeting for the purpose of obtaining information about the foundation trust’s performance of its functions or the directors’ performance of their duties (and deciding whether to propose a vote on the foundation trust’s or directors’ performance).</p>	Not applicable – this power has not been invoked during 2023/24

<b>Code of Governance reference</b>	<b>Summary of requirement</b>	<b>Reference in Annual Report/ Response</b>
	** As inserted by section 151 (6) of the Health and Social Care Act 2012)	

#### 5.4 Comply or explain requirements

The Trust believes it complies with all of the requirements of the Code of Governance in the “comply or explain” category.



Matthew Hartland

Chief Executive  
25 June 2025

## Section 6: Regulatory Ratings Report

### 6.1 NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing Integrated Care Boards and providers and identifying potential support needs. The framework looks at five themes:

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- Finance and use of resources
- People
- Leadership and capability

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support and '1' reflects providers with maximum autonomy.

### 6.2 Segmentation

During the year, the Trust undertook a self-assessment against the NHS Oversight Framework, which was presented to the Birmingham and Solihull Integrated Care Board (ICB). For the first three quarters of the year, performance was confirmed as Segment 2.

However, the Trust has been subsequently notified that it has been reclassified into Segment 3 for the final quarter of the year due to its year-end financial deficit. The Birmingham & Solihull Integrated Care System as a whole remained within Segment 3.

A revised NHS Performance Assessment Framework is being introduced nationally, with an increased focus on organisation-specific, objective metrics. While still under final consultation, this framework is expected to replace the previous segmentation approach. The Trust is preparing for implementation of the new framework and remains committed to improving its position, with the ambition of returning to Segment 2 in quarter one of 2025/26.



Matthew Hartland  
Chief Executive

25 June 2025

## Section 7: Statement of the Chief Executive's responsibilities as the Accounting Officer of The Royal Orthopaedic Hospital NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require The Royal Orthopaedic Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Royal Orthopaedic Hospital NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information. To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Matthew Hartland  
Chief Executive  
25 June 2025

## Section 8: Annual Governance Statement

### 8.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

### 8.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Royal Orthopaedic Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

### 8.3 Capacity to handle risk

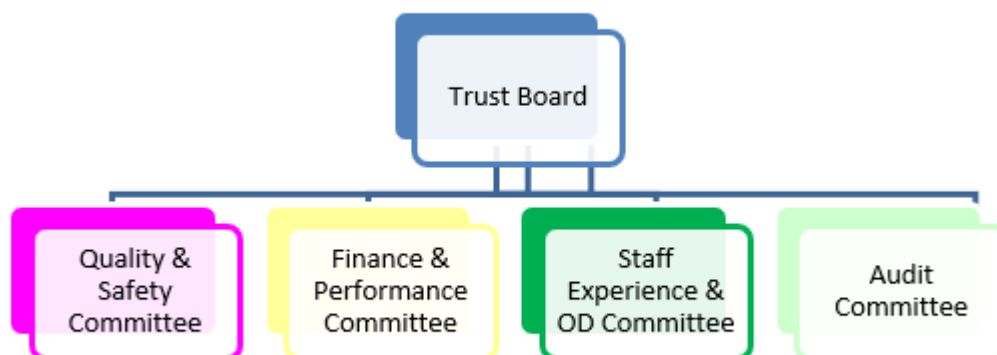
#### 8.3.1 How leadership is given to the risk management process

The Chief Executive has overall responsibility for having an effective risk management system in place within the Trust and for meeting all statutory requirements. At an operational level, the Executive Director of Governance oversees the risk management framework within the Trust.

The Trust Board has four primary committees to oversee risk management: the Quality & Safety Committee, the Finance & Performance Committee, the Audit Committee and the Staff Experience & Organisational Development Committee. Figure 1 sets out the reporting Board & Committee framework within the Trust.

*Note – the Trust also has in place a Nominations & Remuneration Committee (Executive Directors), although this does not form part of the core risk management framework.*

Figure 1: Trust Board &amp; Committee structure



**Quality & Safety Committee:** The Quality & Safety Committee has designated responsibility for oversight of clinical risk management and is chaired by a Non-Executive Director of the Trust. The Executive Chief Nurse and Executive Medical Director are the joint lead executives for this committee. The Committee meets on alternate months. The Committee regularly reviews clinical risks through consideration of a Quality & Patient Safety overview. The Committee's cycle of routine business also requires a set of subcommittees and groups with a clinical focus to report to the Committee on their work and to highlight any risks within their remit which may not otherwise be included on the formal risk registers. This process includes the evaluation of mitigating actions that have taken place to understand and assess the outcomes of these actions.

**Finance & Performance Committee:** The Finance & Performance Committee has a designated responsibility for the oversight of the performance of the organisation from a financial and operational perspective and is chaired by a Non-Executive Director of the Trust. The Executive Chief Finance Officer and the Executive Chief Operating Officer are the joint lead executives for this committee. The Committee meets monthly (apart from August and December) and regularly reviews risks associated with the financial position & operational performance through a comprehensive finance and performance overview report.

**Staff Experience & OD Committee:** The Staff Experience & OD Committee has designated responsibility for the oversight of workforce-related matters, including HR performance metrics, delivery of workforce strategies and organisational development. It is chaired by a Non-Executive Director. During the year, the Executive lead for the Committee was the Executive Chief People Officer. The Committee meets on alternate months and regularly reviews risk associated with the Trust's workforce and its development through a workforce overview and reports in line with its annual workplan.

The Quality & Safety, Finance & Performance and the Staff Experience & OD Committees all consider an extract of the Corporate Risk Register and the Board Assurance Framework, which also includes risks pertinent to the remit of the Committee.

**Audit Committee:** The Audit Committee is chaired by a Non-Executive of the Trust and meets five times a year. The Executive Chief Finance Officer is the lead executive for the Committee. The Audit Committee ensures the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance. It maintains an oversight of the foundation trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements. It reviews the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

All committees report back to the Board as part of its formal agenda through the use of an assurance report that presents matters agreed at committee meetings that require escalation or are of concern, positive assurances and decisions taken, together with any key actions that have been taken.

The Chief Executive chairs a weekly meeting of the **Executive Team** comprising all the Executive Directors. The meetings operate to a standard agenda, including updates from the Chief Executive and a welfare check with the Directors, followed by updates and discussions led in rotation by each Officer. A record of actions and decisions taken at the meeting is maintained, which informs the construction of future agendas. The Executive Team meeting provides a forum for the Chief Executive to hold colleagues to account and offers assurance to the Board and its Committees on the day-to-day management and decision-making in the organisation when needed, including via updates back to the Trust Board in its sessions in public on the relevant matters discussed by the Executive Team in the Chief Executive's update. Updates to the Corporate Risk Register are presented to the Executive Team meetings by the Corporate Governance Lead on a quarterly basis. The Executive Team also meets monthly as part of the regular team meeting as the Quality & Safety Executive (QSE), where the focus of the discussion is on clinical governance matters ahead of their consideration at the Quality & Safety Committee of the Board. An upward report from the QSE is presented to the Quality & Safety Committee at each meeting.

Finally, the Trust Board considers its Board Assurance Framework (BAF) at its public sessions at least four times per year. The BAF is aligned to the Trust’s strategy and Executive Team members provide an overview of any changes to risks within their portfolio to which the Board is asked to approve.

The Trust has an electronic risk register system (Ulysses) that facilitates management of both local and corporate risk registers and the Board Assurance Framework and ongoing work is being undertaken to develop the functionality of this system.

### 8.3.2 How staff are trained or equipped to manage risk in a way appropriate to their authority and duties

The education and training of all staff on the principles of risk management is an essential element of the Trust’s Risk Management policy. For part of the year, the Corporate Governance Lead provided personalised training to staff on request or as identified and also attended key operational management meetings to present the risk register and offer support to those wishing to raise a risk or strengthen their knowledge of risk management. However, during the year a package of governance training has been developed which is delivered by key members of the governance team; this includes risk identification and management. The implementation of the new ‘Me as a Manager’ development programme will provide a further opportunity for training within the governance section of the programme. A Standard Operating Procedure is also in place setting out the key elements of discussion needed around risk at corporate forums.

### 8.3.3 Ways in which the Trust seeks to learn from good practice

The Trust seeks to learn from good practice in governance and the management of risk through a number of means including partnering with other organisations, external reviews by experts and internal activities such as trustwide learning events for staff. Work has progressed during the year, but further activity is planned to strengthen the processes for learning and dissemination of lessons from incidents, investigations into these, complaints, Freedom to Speak Up concerns and litigation. The implementation of the Patient Safety Incident Response Framework (PSIRF) has driven forward processes to ensure that the Trust benefits from learning lessons, while at the same time ensuring that there is a more proportionate approach to investigating incidents, particularly where we know that there is already improvement work underway. The monthly quality report which is considered by the Quality & Safety Committee and the Trust Board also includes a number of sections to highlight where lessons have been learned from incidents that have been investigated and remedial action taking. The Trust is embracing the use of the national Learning from Excellence framework and technology, however this is yet to be fully implemented.

## 8.4 The risk and control framework

### 8.4.1 The key elements of the risk management framework

To ensure a consistent approach to risk, the Trust has used during the year, a systematic approach to risk management. The prioritisation of risks is identified through the use of a risk assessment matrix which enables the Trust to assess the level of risk based upon the measurement of likelihood and consequence of occurrence.

Element of Risk	CONSEQUENCE				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
LIKELIHOOD					
5 Certain	5	10	15	20	25
4 Highly Likely	4	8	12	16	20
3 Likely	3	6	9	12	15
2 Possible	2	4	6	8	10
1 Remote/None	1	2	3	4	5

Green = LOW risk

Yellow = MODERATE risk

Amber = MEDIUM risk

Red = HIGH risk

## Figure 2: Risk assessment matrix

The risk management framework includes:

- Identification of hazards and risks and their communication to all stakeholders
- Risk analysis and control including prevention and reduction of loss
- Developing and maintaining a risk register
- Managing, reporting and recording of near misses and incidents
- Investigation of incidents within the Patient Safety Incident Response Framework (PSIRF)
- Complaints and claims management
- Education of staff on safety awareness including feedback from incidents, complaints, claims and Freedom to Speak Up concerns
- Ensuring compliance with law and professional or other relevant standards

During the year, there has been continued good progress with cleansing the content of existing risk registers and the Ulysses system to ensure that only relevant risks remain captured and that actions to mitigate the risks are accurate and robust.

### 8.4.2 How risk appetites are determined

The Trust recognises that eliminating all risk is not possible and that systems of control must not be so rigid that they stifle innovation, creativity and the imaginative use of resources. In this context the Trust Board interprets “acceptable” levels of risk as follows:

An acceptable risk is one which has been accepted after proper evaluation (risk assessment) and is one where effective and appropriate controls have been implemented. The acceptance of a risk should represent an informed decision to accept the likelihood of that risk. It must be:

- Identified and entered on the Risk Register
- Quantified (impact and likelihood)
- Reviewed and have been deemed acceptable by the relevant committee or area
- Controlled and kept under review

As a general principle the Trust will seek to eliminate or control risks which have the potential to:

- Harm patients, staff, volunteers, visitors, contractors and other stakeholders
- Harm the reputation of the organisation
- Have severe financial consequences which would prevent the Trust from carrying out its functions

In recognition that further work was required to embed the Board’s understanding of risk appetite, a session around this was held in November 2023, led by the Governance Team, linking this to the launch of the new Board Assurance Framework and the risks within.

### 8.4.3 The key elements of the quality governance arrangements, including how the quality of performance information is assessed and how assurance is obtained routinely on compliance with CQC registration requirements

The Board receives assurance on the quality of care through the Board Assurance Framework and monitors performance against a wide range of indicators in the monthly Finance & Performance Overview, the Quality & Patient Safety report and Workforce overview.

The Quality & Safety Committee provides upward assurance to the Board on the activities undertaken by its subgroups covering particular aspects of quality, for example safeguarding and infection control. A Quality & Safety Executive forum is also in place to streamline some of the reporting by the governance groups and provide an additional level of oversight before upwardly reporting to the Quality & Safety Committee.

Quality information is also scrutinised by the Clinical Quality Group, one of the bodies upwardly reporting into Quality & Safety Executive, this being chaired by the Deputy Chief Nurse.

The clinical outcomes data is reviewed by the Audit, Quality Improvement, Learning & Analysis (AQILA) panel, a further subgroup of the Quality & Safety Committee with a remit that is complementary to the agenda of the Clinical Quality Group.

The various walkabouts that the Trust operates provide an opportunity to triangulate the information presented within assurance and risk reports with discussions with staff and physical inspection of the environment. The Quality Assurance walkabouts have been undertaken on a regular basis this year, these being aligned to the CQC assessment framework, whereby each area visited is provided with a rating of Outstanding, Good, Requires Improvement or Inadequate. No area visited this year has attracted a rating below Good. The Executive Team also conducts a routine 'Chat & Check' walkabout, visiting both clinical and non-clinical areas of the Trust to understand staff's experience of working at the Trust and to undertake a physical inspection of the areas in which staff are working. A formal Non Executive/Executive walkabouts schedule was launched this year, providing a further opportunity to talk to staff to understand their experience at the ROH and take assurance that processes described in Board and Committee papers are operating as they should.

The Executive Team hosts a monthly briefing with staff from across the Trust, for dissemination of key messages to teams and to receive feedback from the organisation. The Chief Executive from time to time, also arranges special briefings on significant matters of interest to the wider organisation.

During 2024/25, work began to prepare for the next assessment by the CQC, including the identification of evidence to showcase to the CQC that demonstrates the outstanding care we provide to our patients. An initial self-assessment against the CQC well-led quality statements has also been undertaken and the action plan to address areas where compliance could be strengthened is monitored through the Staff Experience & OD Committee. Self-assessments against the other domains of the CQC framework have also been undertaken and are reviewed by the Board committee's relevant to their remit.

Assurance is obtained on compliance with CQC registration requirements on an ongoing basis through updates from Directors and Senior Managers of the Trust holding specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems to support those standards.

Meetings between the CQC Relationship Managers with members of the Executive Team, were held during the year and an on-site engagement visit was also held in October where the ROH teams presented to the CQC some examples of services offered by the Trust.

#### **8.4.4 How risks to data security are being managed and controlled**

The Head of IT Operations is responsible for managing the technical/cyber security aspect of data. The Deputy Head of Cyber & IG and the Information Governance Manager supports the awareness and communications part of this work. Data security and associated risks are monitored via the Information Governance (IG) Group which maintains a risk register and an action plan which addresses issues which are reviewed and actioned quarterly. Lessons learned are fed into training and awareness.

The Data Security & Protection Toolkit (DSPT) is now aligned with the Cyber Assurance Framework (CAF) and used as one of the controls for implementing data security. The action plan to achieve DSPT/CAF assurance is monitored by the IG Group. The Audit Committee has oversight of progress towards meeting the toolkit requirements and the plans to safeguard the Trust against cyber crime. Assessment of compliance with the toolkit and evidential support for this is assessed by Internal Audit as part of its annual workplan.

The core infrastructure has built in data security control features and security threats are monitored. Controls also include software/hardware patching and anti-virus. Encrypted data sticks are not permitted and portable devices are protected by encryption and trust owned tablets/smartphones are monitored via Mobile Device Management (MDM) software. No personal devices can operate on the trust corporate network. Remote access to data is protected by multi factor authentication. The migration of the Trust's infrastructure onto a Cloud-based platform provides additional security for the Trust's data.

The Trust Board receives a monthly update on progress with this work and any exceptions to the programme are highlighted. The Trust has implemented a SOC / Siem solution which monitors the Trust 24/7 for all potential changes in activity and stops anything which is suspicious. The ongoing implementation of Cynerio has given us greater visibility and control over the underlying security of networked medical devices.

Information flows containing personal/sensitive data in and out of the Trust have been identified, recorded, reviewed and risk assessed, and transfer methods changed where required. Information assets (IT systems and paper records) have been recorded and risk assessed to ensure that data is held securely with appropriate access controls in place.

All staff receive annual IG training via mandatory training to ensure up to date knowledge about the importance of cyber security and the confidentiality and security of information.

No incidents have met the threshold for onward reporting to the ICO/DHSC in the Data Security Incident Reporting Toolkit.

## 8.5 Description of the organisation's major risks, including significant clinical risks, separately identifying in-year and future risks, how they are/will be managed and mitigated and how outcomes are/will be assessed

Following the significant work to restructure the Board Assurance Framework last year, further work was undertaken during the 2024/25 to realign the content to the refreshed organisational strategy.

The following is an extract from the Trust's revised Board Assurance Framework, which details the strategic risks aligned to the priorities in the Trust's refreshed strategy and therefore represent the areas where the Trust Board has been focusing its attention in 2024/25 and will continue to focus in 2025/26. The extract also provides a view of the top-rated risks on the Corporate Risk Register that are aligned to the main BAF strategic risks. In terms of the red rated risks, there was little change this year, with finances, potential cyber attacks and aged equipment forming the core risks. In some cases, the emphasis of the risks was changed however, to reflect additional pressures by national guidance received and to reflect new mitigations applied, particularly regarding the Trust's estate and equipment. Risks that were removed included the lack of workforce planning capability as this was addressed by the recruitment of a dedicated Workforce Planning Manager.

RISK	CONSEQUENCE	IN YEAR/ FUTURE	how they are/will be managed and mitigated and how outcomes are/will be assessed
<b>PRIORITY 1 – OUR CARE</b>			
<i>STRATEGIC RISK</i>			
There is a risk that the Trust will fail to meet its objective of maintaining outstanding, high-quality care across all services and meeting the needs of our patients through continuously improving our services.	Detrimental impact on Patient Safety, the quality of service we provide; and our reputation and rating as a Trust.	F	Mitigations/management: <ul style="list-style-type: none"> <li>Continuously improve our inpatient experience through our Service Accreditation Programme</li> <li>Embed seamless, connected, efficient processes and pathways in readiness for a fully integrated Electronic Patient Record</li> <li>Evolve our JointCare pathway to meet the needs of our joint replacement patients, increasing the number of day case patients we treat</li> <li>Mobilise a suite of meaningful outcome targets that are actively used to improve the quality of care we delivery (including PROMS, National Joint Registry)</li> <li>Implement centralised booking and improved access for patients</li> </ul> Outcome assessment: <ul style="list-style-type: none"> <li>Improved CQC rating when inspected under new Single Assessment Framework</li> </ul>
<i>ALIGNED RISKS</i>			
Lack of resilience around some specialist support services including Speech & Language; histopathology and dietetics	Poor patient experience and adverse clinical outcome of an inpatient stay. Potential cancer target breaches.	IY/F	Mitigations/management: <ul style="list-style-type: none"> <li>Locum support for some services operated through a Service Level Agreement</li> <li>Situation has been escalated to the Birmingham and Solihull Integrated Care Board to identify permanent source of support</li> </ul>

RISK	CONSEQUENCE	IN YEAR/ FUTURE	how they are/will be managed and mitigated and how outcomes are/will be assessed
			Outcome assessment: <ul style="list-style-type: none"> <li>Permanent support arrangements embedded</li> <li>Cancer targets are met</li> </ul>
Risk of patient harm when novel techniques and devices are used in care provision, as happens in research and in service evaluation of a new technology	Potential patient harm occurs, which would create clinical, reputational, and financial adversity	IY/F	Mitigations/management: <ul style="list-style-type: none"> <li>Controls in place through Modern Interventions Panel and Medical Devices Advisory Group</li> </ul> Outcome assessment: <ul style="list-style-type: none"> <li>Good clinical outcomes from treatment using novel techniques</li> <li>No increase in patient safety incidents or harm</li> </ul>
There is a risk that a fully integrated and fully interoperable electronic patient record (EPR) will not be achieved in the required timelines	The Trust operates using disparate systems that are inefficient and do not streamline clinical information and activity	F	Mitigations/management: <ul style="list-style-type: none"> <li>Implementation of clinical portal to reduce risk pre-implementation of EPR</li> <li>Completion of required business cases &amp; procurement process for EPR</li> <li>Board oversight of plans as a standing agenda item</li> </ul> Outcome assessment: <ul style="list-style-type: none"> <li>EPR implemented to the needs of the Trust in 2026-27</li> </ul>

PRIORITY 2 – OUR EXPERTISE			
<i>STRATEGIC RISK</i>			
There is a risk that the Trust will fail to increase our influence as the leading centre for orthopaedic surgery and MSK care through our cutting-edge research and MSK Academy	Failure to keep pace or ahead of technological gains which would benefit patients.  Failure to teach and train our staff  Failure to continuously improve the quality of our work or maintain and monitor standards	F	Mitigations/management: <ul style="list-style-type: none"> <li>Building ROH into a leading centre for cutting edge innovation, including robotic assisted surgery, Osseointegration, Metastatic Bone Disease</li> <li>Deliver years 3-5 of Research &amp; Development Plan</li> <li>Accreditation as a Major Revision Centre</li> <li>Growing the ROH MSK Academy, designing and delivering education for NHS colleagues, patients and communities</li> <li>Supporting the professional development of ROH staff (detail)</li> </ul>

			<ul style="list-style-type: none"> <li>• Excellence in High Volume Low Complexity procedures and maintaining GIRFT accreditation</li> <li>• Leadership in MSK and Orthopaedics</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>• Positive press, media and partner opinion on the services of the ROH</li> <li>• Positive patient feedback</li> <li>• Accreditation as a GIRFT centre retained</li> </ul>
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**ALIGNED RISKS**

<p>There is a risk that patients may come to harm as a result of their long wait if there is insufficient capacity to deliver the work required in the context of mutual aid. The wait may be due to intrinsic factors within the Trust or the Trust may inherit a risk transferred from other providers as part of mutual aid arrangements.</p>	<ul style="list-style-type: none"> <li>• Patients wait excessively long time before treatment</li> <li>• Potential deterioration or harm to patients</li> <li>• Reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accreditations</li> </ul>	IY/F	<p>Mitigations/management:</p> <ul style="list-style-type: none"> <li>• Patients waiting in excess of 52 weeks are subject to the Trust harm review process.</li> <li>• Harm review process refreshed and published</li> <li>• All patients in this category are regularly reviewed by their clinical teams on a monthly basis.</li> <li>• Refreshed trajectory developed to take into account the mutual aid support</li> <li>• Continued transformation of Outpatients services maximising the digital opportunities.</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>• Improved performance against constitutional targets</li> <li>• No evidence of increase harm to patients</li> </ul>
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**PRIORITY 3 – OUR PEOPLE**

**STRATEGIC RISK**

<p>There is a risk that the Trust will fail to meet its objective of being rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey, recognising our commitment towards inclusivity and wellbeing for all</p>	<p>The culture within the Trust and also the potential impact on our ability to deliver large aspects of the Trust's Strategy (for example our ability to provide outstanding care, our ability to continue to provide our current level of service, our sustainability, our ability to expand and innovate, our inability to address health inequalities within our region and our ability to collaborate and contribute to wider system work.</p>	IY/F	<p>Mitigations/management:</p> <ul style="list-style-type: none"> <li>• Delivery of the Trust's People Plan</li> <li>• Implementation of 'Me As Manager' programme</li> <li>• Flexible Working opportunities</li> <li>• Strengthened Performance Management framework</li> <li>• Embed Race Equality Code</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>• Positive national staff survey results when compared to peers</li> </ul>
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			<ul style="list-style-type: none"> <li>• Reduced turnover rates</li> <li>• Evidence of staff willing to speak up about concerns and high degree of confidence that action will be taken when speaking up</li> </ul>
<b>ALIGNED RISKS</b>			
<p>There is a risk that the trust fails to reach its People Plan target for workforce planning and reduction in agency spend. This is potentially caused by an overreliance on agency staff due to an inability to attract and retain staff, lack of finances to fill vacancies, a lack of workforce establishment planning and succession planning, a lack of talent management and staff development plans. This would have a negative consequence on activity, productivity and efficiency, financial performance, quality of care and patient safety, CQC rating, staff wellbeing and the reputation of the Trust.</p>	<ul style="list-style-type: none"> <li>• Poor patient and staff experience</li> <li>• Failure to meet national imperative to reduce spend on temporary staffing leading to regulatory scrutiny and action</li> </ul>	IY/F	<p>Mitigations/management:</p> <ul style="list-style-type: none"> <li>• Follow up of work commissioned with Midlands and Lancashire Clinical Support unit to identify priorities for strategic workforce planning</li> <li>• Delivery of Workforce planning internal audit recommendations</li> <li>• Monitoring of workforce planning activity by Staff Experience &amp; OD Committee</li> <li>• Employment of workforce planning specialist</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>• Delivery of strategic workforce plan</li> <li>• Balanced capacity and demand model achieved</li> </ul>
<p>There is a risk that workforce productivity may decline due to stricter vacancy controls, increased workload pressures and insufficient access to training and development, potentially resulting in delayed patient care, increased employee burnout, higher operational costs and reduced employee satisfaction.</p>	<ul style="list-style-type: none"> <li>• Quality of care is compromised</li> <li>• Ongoing financial pressures</li> <li>• Higher levels of incidents associated with human error</li> </ul>	IY/F	<p>Mitigations/management:</p> <ul style="list-style-type: none"> <li>• Wellbeing programme</li> <li>• Robust management of annual leave</li> <li>• Implementation of 'Me as a Manager' programme</li> <li>• Executive and Non Executive walkabouts</li> <li>• Check in item included on agendas of many meetings</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>• Improved engagement and morale scores in national staff survey</li> <li>• Reduction in turnover</li> </ul>
<b>PRIORITY 4 – OUR COMMUNITY</b>			
<b>STRATEGIC RISK</b>			

<p>There is a risk that the Trust will fail to meet its objective of being leaders in MSK Prevention across our communities, improving access to our services and increasing the provision of MSK expertise at locality level.</p>	<p>No change or improvement in obtaining access or earlier access to health care for those within our community who would benefit from earlier access to health services, which in turn would help reduce the long-term burden and cost to the NHS if treated earlier</p>	<p>IY/F</p>	<p>Mitigations/management:</p> <ul style="list-style-type: none"> <li>• Deliver our three-year Health Promotion and Prevention Plan, using our orthopaedic and MSK expertise to build tools and develop services for our partners and communities</li> <li>• Deliver a rolling programme of Community Appointment Days and Community Roadshows to provide condition and community specific MSK advice &amp; signposting</li> <li>• Implemented a new MSK workforce model through the MSK Transformation Programme</li> <li>• Embed engagement and co-production into our services to ensure people help design and deliver the services they need</li> <li>• Utilise digital technology to optimise how patients access ROH services (Clinical Decision Support, Self-Management, AI, Triage)</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>• Evidence that hard to reach communities are represented on the Trust’s waiting list</li> <li>• Revised access policy to take into account the need to address health inequalities</li> </ul>
<p><b>ALIGNED RISKS</b></p>			
<p>Limited resource to undertake engagement activities with Primary Care, there is reduced ability to access hard to reach communities</p>	<ul style="list-style-type: none"> <li>• Lack of engagement leading to a poor understanding of the extent of health inequalities in the region</li> <li>• Health inequalities persist and those needing treatment most are not seen in a timely way</li> </ul>	<p>IY/F</p>	<p>Mitigations/management:</p> <ul style="list-style-type: none"> <li>• Development of the Private Practice/GP liaison function</li> <li>• Additional support offered to develop communications tools for the Primary Care liaison work</li> <li>• Delivery of the health inequalities plan</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>• GP liaison team expanded to support delivery of revised communications and an engaged programme</li> <li>• Primary Care engagement events held and well attended</li> </ul>
<p><b>PRIORITY 5 – OUR SUSTAINABILITY</b></p>			
<p><b>STRATEGIC RISK</b></p>			
<p>There is a risk that the Trust will fail to meet its objective to By 2028, the ROH will be financially sustainable, having</p>	<p>Increased restrictions on ability to make strategic and operational management decisions independently; further financial controls;</p>	<p>F</p>	<p>Mitigations/management:</p> <ul style="list-style-type: none"> <li>• Ambulatory Care Unit – additional theatre capacity</li> </ul>

<p>increased the number of people we treat through continuously improving our processes, standardising pathways and improving productivity</p>	<p>detrimental impact on the achievement of the 6 strategic priorities, reputational damage; and enhanced internal and external reporting and governance requirements; an increase in patient safety incidents; as well as financial and reputational loss and poor compliance with national targets.</p>		<ul style="list-style-type: none"> <li>• Private Patient growth</li> <li>• 7 day working contract change</li> <li>• Commercialising innovation</li> <li>• Specialised service development</li> <li>• Delivering Elective Reform Plan</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>• Stable headcount with appropriate skill mix</li> <li>• Increased activity delivered</li> <li>• Reduced length of stay without increased readmissions</li> </ul>
<p><b>ALIGNED RISKS</b></p>			
<p>Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant impact on clinical services.</p>	<ul style="list-style-type: none"> <li>• Patient treatment cancelled</li> <li>• Deterioration in performance against Constitutional standards</li> </ul>	<p>IY/F</p>	<p>Mitigations/management:</p> <ul style="list-style-type: none"> <li>• Delivery of estates plan</li> <li>• Prioritisation of capital programme</li> <li>• Delivery of routine maintenance schedule</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>• Increased theatre utilisation</li> <li>• Reduction in hospital-instigated cancellations</li> <li>• Performance against constitutional targets</li> <li>• Performance against Model Hospital metrics</li> </ul>
<p>Lack of internal expertise to progress strategic workforce planning</p>	<ul style="list-style-type: none"> <li>• Workforce plans mismatched to demand</li> <li>• Failure to attract high calibre colleagues</li> <li>• Staff turnover exceeds recruitment plan</li> </ul>	<p>IY</p>	<p>Mitigations/management:</p> <ul style="list-style-type: none"> <li>• Follow up of work commissioned with Midlands and Lancashire Clinical Support unit to identify priorities for strategic workforce planning</li> <li>• Delivery of Workforce planning internal audit recommendations</li> <li>• Monitoring of workforce planning activity by Staff Experience &amp; OD Committee</li> <li>• Recruitment of workforce planning specialist</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>• Delivery of strategic workforce plan</li> <li>• Balanced capacity and demand model achieved</li> </ul>

<p>There is a risk that a fully integrated and fully interoperable electronic patient record (EPR) will not be achieved in the required timelines</p>	<ul style="list-style-type: none"> <li>The Trust operates using disparate systems that are inefficient and do not streamline clinical information and activity</li> </ul>	<p>F</p>	<p>Mitigations/management:</p> <ul style="list-style-type: none"> <li>Ongoing discussions with NHS England</li> <li>Completion of required business cases</li> <li>Board oversight of plans</li> <li>Recruitment of EPR Programme Manager and Chief Digital Information Officer</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>EPR implemented to the needs of the Trust in 2025/26</li> </ul>
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**PRIORITY 6 – OUR COLLABORATION**

*STRATEGIC RISK*

<p>There is a risk that the Trust will fail to meet its objective of transforming MSK and Orthopaedic services for our wide-reaching patient population through our strategic partnerships across healthcare, third sector, industry, research and academia.</p>	<p>Financial impact and quality differential, as well as a reputational impact in terms of our alignment, position and standing within BSol ICB</p>	<p>IY/F</p>	<p>Mitigation/Controls:</p> <ul style="list-style-type: none"> <li>Healthcare – leading MSK &amp; Orthopaedics as part of Acute Provider Collaborative</li> <li>Partnerships with Industry</li> <li>R&amp;D initiatives</li> <li>Partnerships with educational establishments</li> <li>Charity networks</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>Consistent clinical outcomes</li> </ul>
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*ALIGNED RISKS*

<p>There is a risk that the funding regime for orthopaedic work does not provide sufficient flexibility to be able to create and deliver a model of standardised care for orthopaedics</p>	<ul style="list-style-type: none"> <li>Delivery of non-standardised care across multiple providers in BSol</li> <li>Potential difference in clinical outcomes between sites of treatment</li> <li>Variable patient experience</li> <li>Inefficiencies created by variation in pathways</li> </ul>	<p>IY/F</p>	<p>Mitigation/Controls:</p> <ul style="list-style-type: none"> <li>Ongoing discussions with NHS England regarding tariff and funding regimes</li> <li>Agreement on strategy for single patient waiting list for orthopaedics in BSol with the ICB</li> <li>Development and delivery of Acute Provider Collaborative</li> <li>Review of benchmarking information through Model Hospital data</li> <li>Delivery of EPR delivery programme</li> </ul> <p>Outcome assessment:</p> <ul style="list-style-type: none"> <li>Improved financial performance</li> <li>Consistent clinical outcomes</li> </ul>
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			<ul style="list-style-type: none"> <li>• Reduced waiting times</li> </ul>
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During the financial year 2024/25, there were two Never Events reported: the first Never Event incident related to the performance of wrong site surgery. The planned surgery was an elective trapeziectomy (an operation to remove an arthritic bone, called trapezium, on the base of the thumb); however, when the surgery was performed the operating surgeon erroneously removed part of the scaphoid instead of the trapezium.

The second Never Event occurred when an incorrect sided tibial component was cemented in place during a total knee replacement (TKR). This was realised intra-operatively and immediately corrected.

Statutory Duty of Candour obligations were discharged, and the patient safety incidents were investigated using the Patient Safety Incident Investigation (PSII) methodology, in accordance with the Patient Safety Incident Response Framework (PSIRF) and the Trust’s Patient Safety Incident Response Plan (PSIRP).

The Never Events were also reported externally via STEIS, as required. The final reports, including the learning will be shared via a Learning On One Page (LOOP) template document in the following forums: divisional governance meetings, Executive Governance Meeting, Clinical Quality Group, Quality and Safety Committee and clinical audit processes. The reports and LOOP documents will also be shared with relevant teams and individuals (where necessary) and also the wider Trust to ensure awareness of the patient safety incidents and that the identified learning is embedded in future clinical and professional practice in order to minimise the chance of incidents of this nature reoccurring.

## 8.6 The principal risks to compliance with the NHS Provider Licence Governance Section

There has been a continued improvement in the arrangements and governance framework in the organisation that provides confidence in the Trust’s ability to comply with the governance conditions of its licence. Following the unification of the corporate and clinical governance portfolios, under the single remit of the Executive Director of Governance, the operational responsibility continues to lie with the Assistant Director of Governance & Risk. The team was joined during the year by a Governance & Assurance Manager, who provides clinical expertise into the governance function and takes the lead in representing governance views in many of the corporate meetings. A new Health & Safety Adviser was also appointed, following the retirement of the previous incumbent. The Complaints and PALS function remains under the remit of the Executive Chief Nurse although there is close working between the Governance Team and the Patient Experience Team to ensure that there is a good triangulation across these systems and processes.

The Corporate Services Manager continues to strengthen the processes for the Trust Board and its Committees and additionally focus on governor development and education. During the year, the Corporate Services Manager also initiated an assessment against the NHS England Insightful Provider Board guidance that was issued in November 2024. Questionnaires were issued to all Board members to gather views around how they felt information was being used to inform Board discussions and decisions. The summary of the feedback and action plan to address any areas where there is felt to be improvements needed will be considered and monitored by the Board as we move into the new financial year.

The Trust underwent an external assessment against the NHS Improvement (now NHS England) Well Led Framework in 2019 which highlighted that there was a good level of control and governance in the organisation. This was undertaken by the Governance arm of Grant Thornton. No member of the Board is affiliated with the company. There is confidence that the sound framework of governance identified has been sustained and improved incrementally, a view reinforced by the refreshed self-assessment against the CQC well-led domain that was undertaken during the year.

The key risk that may impact on the Trust’s ability to declare compliance with NHS Provider Licence Governance requirements during the year, concerned the ability of the Trust to achieve its constitutional standards given the impact on the Trust’s operations by the continued legacy of the COVID pandemic on elective services. There is an improvement in performance however, the Trust has seen an increase in referrals to some specialties and has continued to provide mutual aid to other organisations. There is progress being made to reduce the number of patients waiting more than 52 weeks for treatment, this also being a national imperative.

Further work was undertaken to further strengthen the risk management framework during 2024/25, most notably through the delivery of a set of governance training which included risk management and also the upgrades to the Ulysses risk and incident management system.

## 8.7 How risk management is embedded in the activity of the Trust

The Trust’s risk management processes are embedded within all aspects of service planning, delivery and redesign as a means of prioritising and decision making. These key elements, processes and priorities for the management of risk are required to be applied

locally to all wards, areas, departments and operational management/ service units. As part of the strengthened business planning framework overseen by the Strategy and Finance teams, all areas identify the key risks to the delivery of the annual plans and identify the mitigations in place or to be developed in response to these.

The Corporate Governance Lead provides dedicated support given to improving the quality of risk registers across the organisation, most notably at divisional level, but also at trustwide committee level.

Divisions receive localised risk register reports which are discussed as part of biweekly Divisional Governance Board meetings and specific risk registers have been developed for some of the key operational and clinical fora, such as Clinical Quality Group, Drugs and Therapeutics Committee, Safeguarding Group, Infection Prevention and Control Committee, Information Governance Group, Health & Safety Group and Operational Management Board.

The Executive Team considers on a regular basis, a Corporate Risk Register report which shows progress with delivery of key mitigating actions to address the organisation's key risks. Those risks on the Corporate Risk Register which by the nature of their severity or potential to impact on the delivery of the Trust's strategic objectives are included on the Board Assurance Framework and are highlighted as such.

The Board Assurance Framework (BAF) provides a framework for reporting key information to the Board and is also given oversight by the Audit Committee.

In terms of risk management activity below the level of the BAF and potentially feeding into it, reporting of potential risk situations, adverse incidents, 'near-misses', accidents and concerns is a vital part of managing and controlling risks. The Trust uses the Ulysses system for the reporting of both clinical and non-clinical incidents. This system enables members of staff to report incidents in a timely fashion and allows managers and other relevant individuals to receive real time notification of incidents. This system also allows managers to complete an electronic management review of incidents. All managers are expected to encourage an incident reporting culture and support their staff in utilising the incident reporting system. Ulysses continues to be updated to develop detailed reports in order to provide Divisions and wards with better information on risk. The PSIRF policy which is published in the Trust, standardises the process and ensures effective and accurate reporting of incidents. Incidents are reviewed on a daily basis by the Governance Team to ensure timely escalation of any patient safety queries that may arise as well as to quality check the data inputs.

A monthly meeting of a subset of the Executive Team (the Director of Governance, the Medical Director, Chief Nurse and Chief Operating Officer) is held to review new incidents of note and monitor progress with incident investigations (Patient Safety Incident Investigations (PSIIs), After Action Reviews (AARs)), complaints, Learning from Death cases and claims and to distil any learning from investigations into these which may be shared across the organisation.

The governance trackers containing the detail of the incident investigations and complaints responses are also considered monthly by the Quality & Safety Executive.

Information on all incidents requiring an investigation and any clinical negligence claims is shared with key staff and through the Divisional Management routes.

The Quality & Safety Committee reviews complaints, incidents, litigation and Freedom to Speak Up concerns monthly as part of the routine Quality & Patient Safety report.

## **8.8 How public stakeholders are involved in managing risks which impact on them.**

The Trust is committed to involving stakeholders as appropriate in all areas of the Trust's risk management activities. This includes informing and consulting on the management of any significant risks. Key stakeholders include the Birmingham and Solihull Integrated Care Board (BSol ICB) and its constituent bodies, the Trust's Council of Governors, NHS England, CQC, Specialised Commissioners, Subcontractors, Voluntary Groups, the Trust's membership, patients and the local community. A Patient Engagement and Experience Group is also in place which provide a more strategic focus for discussion around matters affecting public and patients, the functionality of which will be revisited during the coming year.

There is also the regular opportunity to engage on matters through the 'Coffee Catch Up' meetings for patients who have been treated using the JointCare pathway. The Trust Board also hears about specific patient stories at alternate sessions in public, where lessons learned are highlighted, particularly where there is evidence that there has been a shortfall in care or patient experience.

## **8.9 Ways in which the Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which assure the Board that staffing processes are safe, sustainable and effective. Compliance with the 'Developing Workforce Safeguards' recommendations**

The Board of Directors and Board subcommittees, namely Staff Engagement & OD, Finance & Performance and Quality & Safety committees, receive regular reports detailing staffing arrangements in place and provide assurance in respect of staffing being safe, effective and sustainable as outlined in the 'Developing Workforce Safeguards' recommendations. The reports detail areas of risk and mitigation in relation to workforce. Assurance is also provided in respect to key workforce metrics such as (but not limited to) establishment data, sickness absence, turnover and statutory and mandatory training as well as data relating to workforce costs, thereby enabling effective triangulation.

The Trust continues to make progress with delivery of its 5 Year People Plan the focus of which is on ensuring that our people thrive so that they can deliver life changing care to our citizens. The plan is delivered through the People and OD Group which reports to the Staff Experience and Organisational Development Committee of the Board. In 2024/25, the Trust introduced a revised approach to appraisals, reduced agency and bank expenditure and improved its vacancy position. The 'Me as a Manager' development programme was also developed during the year, aimed at upskilling those in leadership roles, with the knowledge and skills needed to succeed in these positions and lead with compassion and integrity.

At System level, our Chief People Officer (CPO) is the ICS Senior Responsible Officer (SRO) for Equality, Diversity, Inclusion and Talent and has worked closely to progress joint workforce priorities with the Birmingham and Solihull Integrated Care Systems People Board. Together with the Chief Nurse, the CPO is also the SRO for one of the workstreams within the '4 Rs' workforce programme: Recruit, Retain, Return, and Role Substitution, aimed at addressing key workforce challenges and improve patient experience.

Workforce (Nursing) operational safeguards are continuously monitored in real time to ensure patient and staff safety. The clinical site team, matron and Heads of Nursing monitor staffing level, using Safercare (allocate) and the Safe Nursing Care Tool embedded in the system to aid with triangulation of safer staffing levels against professional judgement. The Matrons/site team oversee daily staffing huddles, which are designed to ensure skill mix against acuity and to allow the teams to plan ahead for changing staffing and acuity. In addition, the nursing teams carry out twice-yearly establishments reviews, taking into account new roles and how they can ensure career development while ensuring skill mix. Safer staffing levels are reported externally monthly to unify (fill rates, Care Hour Per Patient Day (CHPPD)) and staffing levels are displayed at the entrance of all wards as per the national quality board requirement. Internally this information is presented to the Quality and Safety Committee for assurance.

Talent management and succession planning are also a key feature of the Trust's People Plan, enabling us to focus our attention on more strategic workforce planning in addition to the operational elements. The Trust has been joined by a dedicated Workforce Planning Manager during the year, who has been instrumental in developing a workforce plan for the coming financial year and working through the requirements at a local level.

The Trust has progressed its ambition to become a national leader in Health and Wellbeing. Initiated by the substantive Chief Executive, this is continued to be enacted by the Interim Chief Executive, supported by the Chief People Officer. The Trust regularly reports to Board and Sub Committees in relation to the interventions and support available to staff to maintain their wellbeing with a particular focus given to supporting staff with the Cost-of-Living crisis. In addition, the Trust's Inclusion strategy sets out a clear framework for how we will enable every colleague at the ROH to be their authentic self and this is regularly monitored through assurance reporting to Board and Sub Board. It is anticipated that these specific strategies will positively impact on the future workforce sustainability through improved morale, attendance and retention. Alongside side this, the Board monitors staff retention through monthly reporting.

The Trust's workforce plans are developed in conjunction with the Annual Business Planning cycle and these are revisited through triangulation meetings through divisional meeting structures. Risks and issues are highlighted through the Trust's governance structures. In addition, the Trust benefits from technological workforce solutions such as Allocate to support e-rostering and e-job planning which also covers Allied Health Professionals in addition to Nursing and Medical staff groups.

During the year, the Trust has recruited a dedicated Workforce Planning Manager, who will provide valuable expertise in strengthening capability with forecasting and planning. They will also take responsibility for progressing the recommendations of the Workforce Planning internal audit conducted in 2023/24.

## **8.10 The Trust is fully compliant with the registration requirements of the Care Quality Commission.**

The Trust remains at an overall 'Good' rating following the last CQC inspection in 2019.

The action plan to address any weaknesses identified by the inspection has been revisited this year to confirm that the actions taken remain in place. There is only one action that remains to be closed, which concerns the continuing need to develop solutions to overcome the fragmentation of the Trust's information systems. This will take some time to address, given the need to ensure that major systems align with the Birmingham and Solihull Integrated Care System digital strategy. Work is planned to implement an Electronic Patient Record over the coming two years, which will be a major piece of work to address the CQC recommendation.

The Trust has not received any notifications from the CQC during the year that there have been any concerns of significance from a regulatory perspective.

Following the amendments to the CQC's inspection and assessment framework, work has been undertaken to prepare for an inspection and to understand the requirements of the Single Assessment Framework. The Trust Board was updated on these refreshed plans during the year.

### **8.11 Managing Conflicts of interest guidance**

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

Some dedicated and focused work has been undertaken to ensure that all those covered by the Conflict-of-Interest policy have provided a refreshed declaration covering the current year.

### **8.12 NHS Pension Scheme**

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

### **8.13 Equality and Diversity and sustainability**

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Staff Experience & OD Committee reviews the position against the Workforce Race Equality Standards (WRES) and Disability Workforce Disability Equality Standards (WDES) and Equality & Diversity Standards (EDS2) as part of its routine workplan. The Trust has in place a Multi Minority Ethnicity Group (MMEG) and an Equality & Diversity Group, both having Executive sponsors.

The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

In line with the required disclosure related to the Taskforce on climate-related financial disclosures (TCFD), the ROH confirms the following. The Trust has established the Green Board, the body used to work through and oversee a set of work streams to enable the Trust to consider the effects of its work on climate change and the requirement to deliver a Net Zero NHS. The Trust Board has oversight of this group through the Finance & Performance Committee, into which the Green Board reports. The effects of climate change are considered under the Adaptation (Building & Climate); however, this important topic is also interwoven within the other 'Green Agenda' work streams.

## 8.14 Review of economy, efficiency and effectiveness of the use of resources

The Trust robustly reviews performance throughout the organisation to ensure that resources are used economically, efficiently and effectively. There is a robust budget setting and financial management control system which includes activity related budgets, budget manager meetings, Divisional performance meetings and regular reports to the Trust Board. The budgetary control system is complemented by a clear scheme of delegation and financial approval limits. This process enables regular review of financial performance by highlighting areas of concern via variance analysis.

The Trust is structured into two principal divisions: Patient Services & Access and Patient Support services. These are supported by a number of corporate departments. This arrangement provides a robust structure of accountability for the key elements of the Trust's business. The divisions meet monthly, the agendas covering a review of performance and operations and clinical governance and risk, the latter being supported by members of the Trust's clinical and corporate governance teams. Each division is subject to formal reviews with Executive Directors and further work is planned in 2025/26 to systematise these reviews, improve the process and cycle of review and to develop strengthened lines of accountability to the Executive Team. The intention of these reviews is to combine outcomes with efficiency, effectiveness, use of resources, quality and governance to ensure a holistic view of performance is taken.

The Trust has developed a finance overview; a set of infographics which monitor both national and local targets together with efficiency indicators which are reported on a monthly basis. This is considered and challenged on a monthly basis by the Finance and Performance Committee and also by the Trust Board when it meets in public.

A component of the Trust's financial planning is the implementation and delivery of a Cost Improvement Programme (CIP). Financial delivery against the Trust's CIP has been monitored through the CIP Board during the year and on a divisional basis, through the divisional management boards and the formal executive divisional reviews, with Trust-wide performance monitored and challenged monthly as part of the Finance Overview to the Finance & Performance Committee. Going forward, as part of the new and strengthened governance and oversight framework, progress with the delivery of the CIP schemes of a project nature will be through the Trust Improvement Group and Executive Directors will be held to account for the delivery of CIP schemes and the financial benefits associated with these, through the monthly Financial Delivery Board.

The annual National Cost Collection (NCC) is now embedded across the Acute sector of the NHS and has mandated the patient level data collection for Community and Mental Health providers. The Trust continues to adhere to the national costing guidance and is providing detailed Patient level information to NHSE. The Trust has maintained the overall NHSE's costing assurance tool of 100% ensuring the Trust is fully compliant.

The Board receives regular updates from its Audit Committee on the reviews carried out by both Internal Audit and External Audit. They receive and consider the Internal Auditor's opinion and the Annual Management Letter by the External Auditor which comments on the economy, efficiency and effectiveness of the use of resources. The Audit Committee considers the recommendations from all audits carried out and oversees, by appropriate monitoring of actions taken by responsible officers, any required corrective action needed. The Audit Committee receives regular technical updates from the Trust's external auditor, a number of which have related to a changing external context and the drive for greater efficiency and transformational practice. The Director's report provides further information regarding the committee structure, attendance records and coverage of each of the committees' work.

## 8.15 Information Governance

During the year (April 2024 to March 2025), the Trust reported 33 incidents relating to information governance and data security. None of these met the threshold for reporting to the Information Commissioner and/or the Department of Health and Social Services. For the remaining incidents, common themes were inappropriate access to information or wrong information sent or given, usually caused by one-off staff errors or carelessness through not checking thoroughly. There has also been a small recurrence of staff leaving medical records and confidential paperwork in meeting rooms, but all were recovered by staff and dealt with appropriately. Managers deal with incidents at a local level supported by the Trust's Information Governance Manager, where needed, who then reviews all incidents to identify root causes and any training needs. Incidents and the subsequent learning is monitored by the Information Governance Group and messages are cascaded to staff via training and awareness. Any patients affected by data breaches which are identified by staff or the patients themselves, are informed if it is appropriate and proportionate to do so and provided with explanations and apologies on behalf of the Trust.

## 8.16 Data quality and governance

The Trust has a number of operational and clinical systems that collect and store data about patients. This data is critical to the running of the Trust to ensure effective and timely care to patients and enables the Trust to plan and make future business decisions. High quality data is essential to aid business intelligence reporting and ensure operational efficiency. Ways in which the Trust ensures good data quality include:

- There is a Data Quality Group chaired by the Executive Chief Operating Officer and includes key stakeholders: members from the business intelligence, operations, education and training teams. This group monitors performance against data quality Key Performance Indicators (KPIs), audits and addresses any risks and issues as they arise.
- The Business Intelligence team carries out over 75 automated data quality checks on Trust data, creating reports which highlight data quality issues. These are shared on the Health Informatics dashboard accessible by operational staff to action and resolve.
- The Trust has a Data Validation team focusing on waiting list management which identifies and resolves errors caused by data quality. They also ensure that the Trust adheres to the national validation target, that being that 90% of patients waiting over 12 weeks are to be validated every 12 weeks.
- Key performance indicators are assigned data quality kitemarks to provide assurance of a range of areas including, timeliness, validation, audit, assessment and granularity.
- Clinical coders regularly provide advice to clinical staff to ensure accuracy and depth of coding.

## Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, and its committees, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I can place reliance on the Head of Internal Audit Opinion for 2024/25, which states that *'the organisation has an adequate and effective framework for risk management, governance & internal control. However, our work has identified further enhancements to the framework of risk management, governance & internal control to ensure it remains adequate and effective'*.

The opinion notes that out of the seven assurance reports issued, six provided positive assurance opinions (significant or significant with minor improvement opportunities) and one provided a negative assurance opinion (partial assurance with improvements required), this being associated with Job Planning. The high priority actions arising from this review have been adopted by the Executive Team and are monitored for progress by the Audit Committee. The opinion in the overall report states that in the view of the Head of Internal Audit, there were no specific issues identified during the year that needed to be raised as significant control issues within this Annual Governance Statement.

Other steps taken during 2024/25 to maintain and improve the Trust's systems of internal control include:

- the Audit Committee receives regular reports on reviews undertaken by the Internal and External Auditors, and follow up of any recommendations to ensure that the management team are implementing the agreed improvements to internal control processes within the agreed timeframe or that there are reasonable explanations for variances.

- A refreshed annual work plan for the Board was devised and a Board strategic work & development plan has been produced which was considered at the April 2024 meeting of the Trust Board.
- Implementation of a revised governance framework to provide robust oversight of the work to achieve a satisfactory year end position financially and operationally, with an additional wider focus on productivity and efficiency.
- Development of an enhanced governance and oversight framework ready to be implemented in 2025/26 to provide stringent review and challenge on delivery of the Trust's financial, operational and workforce plans.
- Reintroduction of a robust Quality Impact Assessment process to evaluate Cost Improvement Schemes developed and proposed.
- The programme of face to face walkabouts by Non-Executive Directors was refreshed during the year 2024/25.
- Executive 'Chat and Check' visits continued to provide an opportunity for staff to describe to the Executive Team their experience of working at the hospital and for the team to undertake a review of the physical working environment.
- Delivery of the 'Team Brief' presentation has been refreshed to focus delivery of matters of information to the organisation and it continues to include all members of the Executive Team plus specialists across the Trust where the content requires.
- Given the significance of the change, there have been routine updates on the implementation of the Patient Safety Incident Response Framework, including an annual report provided to the Quality & Safety Committee in March 2025.
- Work has been completed to self-assess the organisation's position against the Quality Statements in the CQC Single Assessment Framework and to prepare the organisation for the next inspection.
- The Trust has adopted the requirements of the new Fit and Proper Persons Test and this has been applied as part of the recruitment of new Board members during the year. The self-certification was provided to NHS England as required and returned without any concerns being raised.
- The Board Assurance Framework has been revamped in line with recommendations from the Trust's internal audit function and to realign it to the refreshed Trust strategy.
- The governance team has recruited into all vacant positions, including to a new Governance & Assurance Manager with a clinical and quality improvement skillset.
- Development of a Continuous Improvement programme that extends trustwide.
- Introduction of a Service Accreditation programme.
- Clinical Audit sessions continue to share good practice, learn from experience and improve local clinical governance processes, ensuring there is protected time for teams to come together on a regular basis to review the quality of care provided.
- Recruitment of additional Freedom to Speak Up champions.
- Development of the Trust's staff networks to allow staff to speak up and share experiences that impact on their ability to work well in the organisation; and
- The action plans from the Committee effectiveness reviews have been monitored throughout the year.

During the year and in line with the assurance in the Head of Internal Audit's Opinion, there were no significant internal control issues.

## 8.17 Conclusion

I am assured by the advice I have received about the effective operation of controls across the Trust during the year as confirmed by internal audit, managers, committees of the board and external audit opinion, and I am able to take sufficient assurance that overall, the Trust has a sound system of internal control and there were no significant internal control issues to highlight during the year.

The Trust is committed over 2025/26 to the continued development of our governance and control system building on the progress and learning undertaken in 2024/25 and prior years.



Matthew Hartland  
Chief Executive  
25 June 2025

## GLOSSARY OF TERMS

Acronym	Abbreviation	Meaning
AEO	Accountable Emergency Officer	Member of the Board that oversees the Trust's arrangements for Emergency, Preparedness, Resilience and Response (EPRR)
BON	Birmingham Orthopaedic Network	The official trainee-led collaborative network of the Birmingham Orthopaedic Training programme (BOTP)
CETV	Cash Equivalent Transfer Value	It represents the current monetary value of a defined benefit pension (like a final salary or career average pension) that a member can transfer to another pension arrangement.
DPO	Data Protection Officer	A role mandated by data protection laws like GDPR for certain organisations, including the NHS
FFT	Friends and Family Test	A patient feedback tool used to gather information about the quality of care and services provided by NHS organisations
FR ARM	Financial Reporting and Accounting Reporting Manual	A document which provides guidance for NHS foundation trusts on producing their annual reports and accounts
FRCS	Fellowship of the Royal College of Surgeons	A professional qualification that allows a surgeon to practice in the UK and Ireland
PHSO	Public Health Service Ombudsman	An independent body in the UK that investigates complaints about UK government departments, other public organisations, and the NHS in England
POAC	Pre Operative Admission Centre	Department at the ROH which assesses a patient's readiness for surgery
QIOF	Quality Improvement and Outcomes Framework	Part of the requirement of placement provider organisations in receipt of funding through the NHS Education Contract to ensure that there is a proactive, high quality knowledge and library service that is available to all staff and learners
SIRO	Senior Information Risk Owner	The overall owner of information risk within the organisation and acts as the focal point for information risk management in the Trust
SOCI	Statement of Comprehensive Income	A financial document that summarises a company's financial performance over a specific period, typically a year

# **The Royal Orthopaedic Hospital NHS Foundation Trust**

**Consolidated Accounts for the year  
ended 31 March 2025**

## **Independent auditor's report to the board of governors and board of directors of The Royal Orthopaedic Hospital NHS Foundation Trust**

### **Report on the audit of the financial statements**

#### **Opinion**

In our opinion the financial statements of The Royal Orthopaedic Hospital NHS Foundation Trust (the 'trust') and its subsidiary (the 'group'):

- give a true and fair view of the state of the group's and the foundation trust's affairs as at 31 March 2025 and of the group's and foundation trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the group and foundation trust statements of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of changes in taxpayers' equity;
- the group and foundation trust statements of cash flows; and
- the related notes 1 to 32.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England.

#### **Basis for opinion**

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

#### **Conclusions relating to going concern**

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the group and foundation trust is adopted in consideration of the requirements set out in the Department of Health and Social Care Group Accounting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

**Other information**

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

**Responsibilities of accounting officer**

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

**Auditor's responsibilities for the audit of the financial statements**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: [www.frc.org.uk/auditorsresponsibilities](http://www.frc.org.uk/auditorsresponsibilities). This description forms part of our auditor's report.

### **Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud**

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

We considered the nature of the group and its control environment, and reviewed the group's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit, and local counter fraud about their own identification and assessment of the risks of irregularities, including those that are specific to the National Health Service and public sector.

We obtained an understanding of the legal and regulatory framework that the group operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the group's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuations and IT specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following area, and our specific procedures performed to address it are described below:

- the completeness and timing of recognition of accruals and related expenditure is subject to potential management bias: we tested a sample of accruals to supporting documentation to assess the adequacy of the recorded amount; we tested a sample of post year-end payments to test whether items representing liabilities at 31 March 2025 had been appropriately recognised; we assessed provisions against the IAS 37 criteria to conclude on their likelihood and potential impact for the group and foundation trust; we reviewed journal transactions for debits to accruals as part of the close process and tested a sample of these adjustments.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;

- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, and reviewing internal audit reports.

### **Report on other legal and regulatory requirements**

#### **Opinions on other matters prescribed by the National Health Service Act 2006**

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

### **Matters on which we are required to report by exception**

#### ***Use of resources***

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of this matter.

#### **Respective responsibilities of the accountable officer and auditor relating to the trust's arrangements for securing economy, efficiency and effectiveness in the use of resources**

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the Auditor Guidance Notes issued by the Comptroller & Auditor General, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its

use of resources for the year ended 31 March 2025. Other findings from our work, including our commentary on the trust's arrangements, will be reported in our separate Auditor's Annual Report.

### ***Annual Governance Statement and compilation of financial statements***

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

### ***Reports in the public interest or to the regulator***

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

### ***Delay in certification of completion of the audit***

As at the date of this audit report, we have not yet completed our work in respect of the Trust's consolidation returns for the year ended 31 March 2025 and have not received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete.

In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of The Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of the National Health Service Act 2006 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

### ***Use of our report***

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of The Royal Orthopaedic Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not

accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

*Kelly de Gersigny*

Kelly de Gersigny (Engagement Lead)  
For and on behalf of Deloitte LLP  
Appointed Auditor  
London, United Kingdom  
27 June 2025

**Foreword to the accounts**

**The Royal Orthopaedic Hospital NHS Foundation Trust**

These accounts, for the year ended 31 March 2025, have been prepared by The Royal Orthopaedic Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.



**Mr Matthew Hartland**

**Accountable Officer**

Dated 25 June 2025

**THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST  
CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR  
ENDED 31 MARCH 2025**

	Note	Group	
		2024/25 £000	2023/24 £000
Operating income from patient care activities	3	140,636	129,534
Other operating income	4	9,752	6,172
Operating expenses	6,8	<u>(151,339)</u>	<u>(139,687)</u>
<b>Operating deficit from continuing operations</b>		<b><u>(951)</u></b>	<b><u>(3,981)</u></b>
Finance income	10	440	413
Finance expenses	10.1	(329)	(430)
PDC dividends payable		<u>(1,283)</u>	<u>(1,400)</u>
<b>Net finance costs</b>		<b><u>(1,172)</u></b>	<b><u>(1,417)</u></b>
Other gains	11	-	1
<b>Deficit for the year from continuing operations</b>		<b><u>(2,123)</u></b>	<b><u>(5,397)</u></b>
<b>Deficit for the year</b>		<b><u>(2,123)</u></b>	<b><u>(5,397)</u></b>
<b>Other comprehensive income</b>			
<b>Will not be reclassified to income and expenditure:</b>			
Reversal of impairment / (Impairment)	7	830	(2,814)
Revaluations	7	-	957
<b>May be reclassified to income and expenditure when certain conditions are met:</b>			
Fair value (losses) / gains on financial assets mandated at fair value through OCI	18	<u>(15)</u>	<u>55</u>
<b>Total comprehensive (expense) for the period</b>		<b><u>(1,308)</u></b>	<b><u>(7,199)</u></b>

All income and expenditure are derived from continuing operations. There is no surplus attributable to minority interests.

As permitted by the Department of Health and Social Care Group Accounting Manual, the Trust has taken the exemption afforded by Section 408 of the Companies Act 2006 not to present its own income statement and statement of comprehensive income.

The Trust had a deficit of (£1,717,000) (2023/24: £5,134,000 deficit), and a total comprehensive deficit (after impairments and revaluations) of (£887,000) (2023/24 £6,991,000 deficit). The Group returned a deficit of (£2,123,000) (2023/24: £5,397,000 deficit).

There was a total of (£79k intercompany eliminations to income relating to income from the charity moving the Trust element of the deficit to (1796) the charity excess expenditure over income was (£327k).

**THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST**  
**CONSOLIDATED AND TRUST STATEMENT OF FINANCIAL POSITION AS AT 31**  
**MARCH 2025**

		Group		Trust	
	Not e	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
<b>Non-current assets</b>					
Intangible assets	13	933	981	933	981
Property, plant and equipment	14	53,455	49,473	53,455	49,473
Right of use assets	17	13,404	15,925	13,404	15,925
Other investments / financial assets	18	947	962	-	-
<b>Total non-current assets</b>		<b>68,739</b>	<b>67,341</b>	<b>67,792</b>	<b>66,379</b>
<b>Current assets</b>					
Inventories	20	-	1	-	1
Receivables	21	18,307	8,194	18,296	8,193
Other investments / financial assets	18	211	164	-	-
Cash and cash equivalents	23	3,757	2,583	3,293	1,699
<b>Total current assets</b>		<b>22,275</b>	<b>10,942</b>	<b>21,589</b>	<b>9,893</b>
<b>Current liabilities</b>					
Trade and other payables	24	(18,001)	(13,903)	(17,951)	(13,896)
Borrowings	27	(2,888)	(3,190)	(2,888)	(3,190)
Provisions	27.2	(1,833)	(13)	(1,833)	(13)
Other liabilities	26	(6,332)	(1,233)	(6,332)	(1,233)
<b>Total current liabilities</b>		<b>(29,054)</b>	<b>(18,339)</b>	<b>(29,004)</b>	<b>(18,332)</b>
<b>Total assets less current liabilities</b>		<b>61,960</b>	<b>59,944</b>	<b>60,377</b>	<b>57,940</b>
<b>Non-current liabilities</b>					
Borrowings	27	(10,834)	(12,955)	(10,834)	(12,955)
Provisions	27.2	(1,181)	(1,174)	(1,181)	(1,174)
<b>Total non-current liabilities</b>		<b>(12,015)</b>	<b>(14,129)</b>	<b>(12,015)</b>	<b>(14,129)</b>
<b>Total assets employed</b>		<b>49,945</b>	<b>45,815</b>	<b>48,362</b>	<b>43,811</b>
<b>Financed by</b>					
Public dividend capital		66,104	60,666	66,104	60,666
Revaluation reserve		2,329	1,499	2,329	1,499
Income and expenditure reserve		(20,071)	(18,354)	(20,071)	(18,354)
Charitable fund reserves	19	1,583	2,004	0	0
<b>Total taxpayers' equity</b>		<b>49,945</b>	<b>45,815</b>	<b>48,362</b>	<b>43,811</b>

The notes on pages 140 to 177 form part of these accounts.

The financial statements were approved by the Board of Directors on 25 June 2025 and are signed on its behalf by:



Mr Matthew Hartland – Chief Executive Officer 25 June 2025

**THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST**  
**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2025**

	Group					Trust			
	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000				
<b>Taxpayers' and others' equity at 1 April 2024 - brought forward</b>	<b>60,666</b>	<b>1,499</b>	<b>(18,354)</b>	<b>2,004</b>	<b>45,815</b>	<b>60,666</b>	<b>1,499</b>	<b>(18,354)</b>	<b>43,811</b>
Surplus/(deficit) for the year	-	-	(1,796)	(327)	(2,123)	-	-	(1,796)	(1,796)
Reversal of Impairments	-	830	-	-	830	-	830	-	830
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	(15)	(15)	-	-	-	-
Public dividend capital received	5,438	-	-	-	5,438	5,438	-	-	5,438
Other reserve movements	-	-	79	(79)	-	-	-	79	79
<b>Taxpayers' and others' equity at 31 March 2025</b>	<b>66,104</b>	<b>2,329</b>	<b>(20,071)</b>	<b>1,583</b>	<b>49,945</b>	<b>66,104</b>	<b>2,329</b>	<b>(20,071)</b>	<b>48,362</b>

**Consolidated Statement of Changes in Equity for the year ended 31 March 2024**

	Group					Trust			
	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000				
<b>Taxpayers' and others' equity at 1 April 2023 - brought forward</b>	<b>60,605</b>	<b>3,356</b>	<b>(13,220)</b>	<b>2,212</b>	<b>52,953</b>	<b>60,605</b>	<b>3,356</b>	<b>(13,220)</b>	<b>50,741</b>
Surplus/(deficit) for the year	-	-	(5,247)	(150)	(5,397)	-	-	(5,247)	(5,247)
Impairments	-	(2,814)	-	-	(2,814)	-	(2,814)	-	(2,814)
Revaluations	-	957	-	-	957	-	957	-	957
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	55	55	-	-	-	-
Public dividend capital received	61	-	-	-	61	61	-	-	61
Other reserve movements	-	-	113	(113)	-	-	-	113	113
<b>Taxpayers' and others' equity at 31 March 2024</b>	<b>60,666</b>	<b>1,499</b>	<b>(18,354)</b>	<b>2,004</b>	<b>45,815</b>	<b>60,666</b>	<b>1,499</b>	<b>(18,354)</b>	<b>43,811</b>

**Information on reserves****Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

**Revaluation reserve**

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

**Income and expenditure reserve**

The balance of this reserve is the accumulated surpluses and deficits of the trust.

**Charitable funds reserve**

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 19.

**THE ROYAL ORTHOPAEDIC HOPITAL NHS FOUNDATION TRUST  
CONSOLIDATED AND TRUST STATEMENT OF CASH FLOWS FOR THE YEAR  
ENDED 31 MARCH 2025**

	Note	Group		Trust	
		2024/25 £000	2023/24 £000	2024/25 £000	2023/24 £000
<b>Cash flows from operating activities</b>					
Operating deficit		(951)	(3,619)	(495)	(3,309)
<b>Non-cash income and expense:</b>				-	-
Depreciation and amortisation	6	6,007	5,889	6,007	5,889
Net impairments	7	(4)	(16)	(4)	(16)
(Increase) / decrease in receivables and other assets		(10,035)	4,577	(10,035)	4,577
(Increase) / decrease in inventories		1	18	1	18
Increase / (decrease) in payables and other liabilities		8,458	(5,939)	8,458	(5,934)
Increase / (decrease) in provisions		1,782	(221)	1,782	(221)
Movements in charitable fund working capital		33	(6)	-	(6)
Other movements in operating cash flows		3	1	-	1
<b>Net cash flows from / (used in) operating activities</b>		<b>5,294</b>	<b>684</b>	<b>5,714</b>	<b>999</b>
<b>Cash flows from investing activities</b>					
Interest received	10	390	366	390	366
Purchase of intangible assets	13	(294)	(24)	(294)	(24)
Purchase of PPE and investment property		(5,245)	(2,844)	(5,245)	(2,844)
<b>Net cash flows from / (used in) investing activities</b>		<b>(5,149)</b>	<b>(2,502)</b>	<b>(5,149)</b>	<b>(2,502)</b>
<b>Cash flows from financing activities</b>					
Public dividend capital received		5,438	61	5,438	61
Capital element of lease liability repayments		(2,888)	(2,768)	(2,888)	(2,768)
Interest paid on lease liability repayments		(284)	(351)	(284)	(351)
PDC dividend (paid)		(1,237)	(1,331)	(1,237)	(1,331)
<b>Net cash flows from / (used in) financing activities</b>		<b>1,029</b>	<b>(4,389)</b>	<b>1,029</b>	<b>(4,389)</b>
<b>Increase / (decrease) in cash and cash equivalents</b>		<b>1,174</b>	<b>(6,207)</b>	<b>1,594</b>	<b>(5,892)</b>
<b>Cash and cash equivalents at 1 April - brought forward</b>		<b>2,583</b>	<b>8,790</b>	<b>1,699</b>	<b>7,591</b>
<b>Cash and cash equivalents at 31 March</b>	23	<b>3,757</b>	<b>2,583</b>	<b>3,293</b>	<b>1,699</b>

## Notes to the Accounts

### Note 1 Accounting policies and other information

#### Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the circumstances of the Trust for the purpose of giving a true and fair view has been selected. The policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

#### Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

#### Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

#### Note 1.3 Consolidation

##### NHS Charitable Funds

The trust is the corporate trustee to The Royal Orthopaedic Hospital NHS Foundation Trust charitable fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

#### The Charitable Fund's main accounting policies are as follows:

##### Incoming resources

Income is recognised when the Charity has entitlement to the funds, any performance conditions attached to the item(s) of income have been met, it is probable that the income will be received, and the amount can be measured reliably.

Donated professional services and donated facilities are recognised as income when the charity has control over the item, any conditions associated with the donated item have been met, the receipt of economic benefit from the use by the charity of the item is probable and that economic benefit can be measured reliably. In accordance with the Charities SORP (FRS 102), general volunteer time is not recognised - refer to the trustees' annual report for more information about their contribution.

On receipt, donated professional services and donated facilities are recognised on the basis of the value of the gift to the charity which is the amount the charity would have been willing to pay to obtain services or facilities of equivalent economic benefit on the open market; a corresponding amount is then recognised in expenditure in the period of receipt.

## Resources expended

Expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party, it is probable that settlement will be required, and the amount of the obligation can be measured reliably.

## Fund accounting

Restricted funds are funds subject to specific restrictions imposed by the funding authorities and donors. These funds are not available for the Trustees to apply at their discretion. The purpose and use of the restricted funds is set out in the notes to the charity's financial statements.

All incoming resources are included in full in the Statement of Financial Activities as soon as the following four factors can be met:

- I. entitlement - arises when a particular resource is receivable, or the Charity's right becomes legally enforceable;
- II. certainty - when the trustees are virtually certain that the incoming resources will be received;
- III. measurement - when the monetary value of the incoming resources can be measured with sufficient reliability; and
- IV. apportionment - incoming resources that are not specifically attributable to a fund are apportioned quarterly pro rata to the value of each fund.

## Investment management costs

Investment management costs are the fees charged by Casenove for the management of the investment portfolio and are apportioned on the basis of fund values. The Trust is not currently incurring any investment management costs as part of its arrangement with Casenove.

## Grants payable

Grants payable are payments, made to third parties (including NHS bodies) in the furtherance of the Trust's charitable objectives to relieve those who are in poor health. They are accounted for on an accrual's basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant.

## Non-current asset investments

Non-current asset investments are shown at market value. All investments are held by the associated Charity what have been consolidated within the Trust accounts. The Charity does not hold any property assets. Quoted stocks and shares are included in the statement of financial position at mid-market price, ex div. Other non-current asset investments are included at Trustees' best estimate of market value.

## Current asset investments

All investments are held by the associated Charity what have been consolidated within the Trust accounts. The current asset investment comprises of cash balances available for investment which are held in capital or income accounts. The investments generate dividends and interest, less any administration costs.

## Realised gains and losses

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

## Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in

that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

### Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

In 2024/25 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 75% of the tariff price.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

### Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases, it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

### NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

### Note 1.5 Other forms of income

#### Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider

from the Trust's Apprenticeship Service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

## **Note 1.6 Expenditure on employee benefits**

### **Short-term employee benefits**

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

### **Pension costs**

#### *NHS Pension Scheme*

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment. Full pension note can be found at Note 9.

## **Note 1.7 Expenditure on other goods and services**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

## **Note 1.8 Property, plant and equipment**

### **Recognition**

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes.
- it is probable that future economic benefits will flow to, or service potential be provided to the trust.
- it is expected to be used for more than one financial year.
- the cost of the item can be measured reliably.
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- form part of the initial setting-up cost of a new building or a refurbishment of a ward or unit, irrespective of their individual or collective cost;
- professional fees such as legal costs, design costs, planning fees and feasibility studies incurred in the construction/bringing the asset into use.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

### *Subsequent expenditure*

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined

reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

### Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	<b>Min life</b>	<b>Max life</b>
	<b>Years</b>	<b>Years</b>
Land	N/A	N/A
Buildings, excluding dwellings	23	55
Dwellings	28	28
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	10
Furniture & fittings	2	5

### Measurement

#### *Valuation*

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back-office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed by an independent valuer with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

Land and non-specialised buildings – market value for existing use.

Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

#### *Depreciation*

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

#### *Revaluation gains and losses*

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

A valuation exercise was carried out during the year by professionally qualified valuers Geraldeve in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last independent "full" asset valuations were undertaken on 31 March 2020 by Cushman and Wakefield (MRICS).

#### *Impairments*

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

During 2024/25, a full revaluation of the Trust's land and buildings was undertaken by Gerald Eve as at 31 March 2025. The revaluation exercise resulted in a reversal of previous impairments totalling £830k recognised in the revaluation reserve. This arose due to an uplift in valuation of certain buildings following updated assumptions in the DRC valuation model, including revised build cost indices and service potential. These movements reflect routine revaluation updates under the Trust's accounting policy, aligned to HM Treasury and DHSC guidance.

#### **De-recognition**

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged, and the assets are not revalued, except where the 'fair value less costs

to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

### **Donated and grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

### **Leased Assets**

Leased assets are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability.

Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement components of the asset.

#### *Initial recognition*

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

#### *Subsequent measurement*

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from price increases, the Trust remeasures the liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income. Any maintenance charge is recognised in operating expenses in the Statement of Comprehensive Income.

### **Note 1.9 Intangible assets**

#### **Recognition**

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

#### *Internally generated intangible assets*

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

### Software

Software, which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software, which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Intangible fixed assets are capitalised when:

- They are capable of being used in trusts activities for more than one year;
- They can be reliably valued; and
- They have a cost of at least £5,000.

Purchased computer software licenses are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the license and their useful economic lives.

### Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

### Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	<b>Min life</b>	<b>Max life</b>
	<b>Years</b>	<b>Years</b>
Software licences	3	7

### Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

**Note 1.11 Cash and cash equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

**Note 1.12 Financial assets and financial liabilities****Recognition**

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

The Trust uses an ageing-based approach to assess expected credit losses, applying risk-adjusted loss rates to each ageing category of receivables. These loss rates are reviewed annually based on historical recovery patterns and any known changes in debtor risk. A receivable is considered to be in default where there is evidence of significant deterioration in credit quality, such as balances aged over 12 months or where recovery is no longer deemed probable.

The Trust does not hold financial instruments such as loan commitments or financial guarantees. Credit risk arises principally from trade and contract receivables, which are accounted for using the simplified approach under IFRS 9. Lifetime expected credit losses are applied from initial recognition. The Trust does not assign formal credit risk grades to receivables but assesses risk based on ageing and known recovery issues. Receivables are grouped by age and nature (e.g. NHS, non-NHS, private), and expected loss rates are applied accordingly.

The Trust's receivables are primarily with public sector bodies and NHS commissioners, with no significant concentration of credit risk. Receivables from other counterparties, including individuals and third-party organisations, are monitored regularly and subject to appropriate provision for expected credit loss.

**Classification and measurement**

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through other comprehensive income in relation to the investments held by the charity.

Financial liabilities classified as subsequently measured at amortised cost. The key assumptions for DRC included estimated build costs per square metre, standard asset lives, location adjustment factors and judgement on service capacity and economic life. Where applicable, valuations included indexation and professional judgement where direct market evidence was unavailable. For Leased assets amortised cost is calculated based on either an uplift in the payments schedule (remeasurement) or revaluation of the assets.

**Financial assets and financial liabilities at amortised cost**

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

### **Financial assets measured at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

### **Impairment of financial assets**

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Management use their judgement to decide when to write off receivables or to provide against the probability of not being able to collect the outstanding debt. Credit losses cover contract receivables as well as private patients' debt.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

### **Derecognition**

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled, or expires.

### **Note 1.13 Leases**

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

## **The Trust as a lessee**

### *Recognition and initial measurement*

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments include fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

### *Subsequent measurement*

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

## **The Trust as a lessor**

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

### *Finance leases*

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

### *Operating leases*

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

#### Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very Long Term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
<u>Year 1</u>	<u>2.60%</u>	<u>3.60%</u>
<u>Year 2</u>	<u>2.30%</u>	<u>1.80%</u>
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%). There are currently two ongoing claims included within provisions calculated using the invoices and notifications received and applying the treasury discount rate. The value of these and 'in year' movements are disclosed in Note 27.2. for the current year being £150k (2023/24: £156k).

#### Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 27.3 but is not recognised in the Trust's accounts.

#### Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

#### Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets but would be disclosed by way of note where an inflow of economic benefits is probable. There are no such assets to report within these accounts.

Contingent liabilities are not recognised but would be disclosed by way of note unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

No contingent assets or liabilities have been identified for disclosure in this reporting period (2023/24 nil).

#### **Note 1.16 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. In 2024/25 the trust received £5.438m (2023/24 £61k).

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trustsand-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

#### **Note 1.17 Value added tax**

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

#### **Note 1.18 Climate change levy**

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

#### **Note 1.19 Foreign exchange**

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

monetary items are translated at the spot exchange rate on 31 March;

non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and

non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

#### **Note 1.20 Third party assets**

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*. There are no such Third-Party assets held.

#### **Note 1.21 Losses and special payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accrual's basis.

The losses and special payments note 30 is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

#### **Note 1.22 Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

#### **Note 1.23 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

#### **Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted**

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

*IFRS 17 Insurance Contracts* – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

*IFRS 18 Presentation and Disclosure in Financial Statements* - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

*IFRS 19 Subsidiaries without Public Accountability: Disclosures* - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

*Changes to non-investment asset valuation* – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5-year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.

Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.

Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The impact of applying these changes in future periods will be considered in further detail once the expected NHS approach to application of the standard has been finalised. The trust does not hold any assets valued at alternative site basis.

#### **Note 1.25 Critical judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- Consolidating Charitable Funds – the determination that the funds of the Charity are consolidated – due to having a Corporate Trustee model, where staff of the Royal Orthopaedic Hospital act as Trustees, it is considered that the funds are within the control of the Hospital therefore the decision to consolidate the results has been taken.
- Categorisation of leases as operating or finance leases.
- Lease arrangements are categorised as either operating leases or finance leases in line with the accounting policy above IFRS 16 (see note 1.13).

#### **Note 1.26 Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

##### **Valuation of the Trust's Estate**

A valuation of the Trust's land and buildings was undertaken with an effective date of 31 March 2025 by the Trust's valuer, Gerardeve. The valuations have been undertaken applying the principles of IAS 16 *Property, Plant and Equipment* and RICS advises that assumptions underpinning the concepts of fair value should be explicitly stated and identifies two potential qualifying assumptions:

the Market Value on the assumption that the property is sold as part of the continuing enterprise in occupation (effectively Existing Use Value); or

the Market Value on the assumption that the property is sold following a cessation of the existing operations" (in effect the traditional understanding of Market Value).

The Department of Health and Social Care has indicated that for NHS assets it requires the former assumption to be applied for operational assets; this is the approach that was taken by the valuer. The Market Value used in arriving at fair value for operational assets is therefore subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

The Trust estimates the pattern of consumption of property, plant and equipment by writing assets down on a straight-line basis over useful economic lives. The useful economic lives determined for each asset or group of assets are informed by historical experience or specific information provided by the valuer where appropriate.

## Provisions

Estimates and judgements are also made in respect of provisions for liabilities and charges (see note 27.2) where there is some uncertainty at the Statement of Financial Position date to either the timing or the amount of the Group's financial liability.

Where the effect of the time value of money is significant, the estimate risk-adjusted cash flows are discounted using the discount rates published and maintained by HM Treasury. Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.40% (2023/24 - 2.45%).

The Trust holds a small number of provisions where the value or timing of potential outflows is subject to uncertainty. One provision relates to a historic operational matter currently under internal review, for which a best estimate has been made based on information available at the reporting date. Other provisions, including those relating to staff benefits, are estimated using standard methodologies and are not considered to involve material estimation uncertainty.

### Provision for credit loss of contract receivables

Management use their judgement to decide when to write-off receivables or to provide against the probability of not being able to collect the outstanding debt. Credit losses cover contract receivables as well as private patient debt. Each credit loss is provided for on a case-by-case basis. Where employees due to work demands are unable to accommodate all of their annual leave in any one calendar year there is provision for them to carry forward 5 days into the following annual leave year.

### Annual Leave provision

In accordance with the requirement of IAS 19 Employee Benefits, the Trust provides for unpaid annual leave carried forward by staff at the year end. The total number of annual leave days that each of the Trusts employees has not taken at the year-end is accounted for within the financial statements. The number of unused days is multiplied by the employees' average salary per day, to give the total cost on individual cost centres. Employees who are unable to due to operational reasons to take their annual leave entitlement are allowed to carry forward up to 5 days into the following leave year.

## Note 2 Operating Segments

The Trust Board as 'Chief Operating Decision Maker' considers that all of its activities fall within one material segment, which is the provision of healthcare services. The segmental reporting format applied to these accounts reflects the Trust's management and internal reporting structure.

The Trust has identified five operating segments based on expenditure, being identified by the corporate performance report presented monthly to the board. All five operating segments have similar characteristics, the nature of services is similar, and also the type or class of customer and nature of the regulatory environment are the same. The five operating segments are all active in the same business being the provision of healthcare, thus reporting a single segment of healthcare is consistent with IFRS 8.

The provision of healthcare is within one main geographical segment being the United Kingdom, and materially from Departments of HM Government in England.

The Trust earns the majority of its income from NHS England and its Integrated Care Boards. Revenue from these bodies individually exceeds 10% of total income. All income has been reported within the single operating segment of healthcare services.

<b>GROUP</b>
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	2024/25		2023/24	
	£000's	£000's	£000's	£000's
Income from Whole HM Government	133,815	89.06%	121,532	89.60%
Income from non-HM Government	16,430	10.94%	14,103	10.40%
	<u>150,245</u>	<u>100.00%</u>	<u>135,635</u>	<u>100.00%</u>

### Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Note 3.1 Income from patient care activities (by nature)	2024/25	2023/24
	£000	£000
<b>Acute services</b>		
Income from commissioners under API contracts - variable element*	57,130	61,901
Income from commissioners under API contracts - fixed element*	71,761	56,713
Other NHS clinical income	-	2,419
<b>All services</b>		
Private patient income	5,287	4,115
National pay award central funding***	143	71
Additional pension contribution central funding**	4,924	2,919
Other clinical income	<u>1,391</u>	<u>1,397</u>
<b>Total income from activities</b>	<b><u>140,636</u></b>	<b><u>129,534</u></b>

\*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2024/25 NHS Payment Scheme documentation. <https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

\*\*Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of the employer contributions 23.7% (2023/24: 20.6%) and related NHS England funding 9.4% (2023/24: 6.3%) have been recognised in these accounts.

\*\*\*Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of the pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

### Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2024/25	2023/24
	£000	£000
NHS England	20,361	35,375
Integrated care boards	113,597	88,648
Non-NHS: private patients	5,287	4,115
Non-NHS: overseas patients (chargeable to patient)	6	-
Injury cost recovery scheme	72	124
Non-NHS: other	<u>1,313</u>	<u>1,273</u>
<b>Total income from activities</b>	<b><u>140,636</u></b>	<b><u>129,534</u></b>
<b>Of which:</b>		
Related to continuing operations	140,636	129,534
Related to discontinued operations	-	-

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services, Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure.

The Trust has deemed all income from patient care activities as being in relation to commissioner related services except for any private patient income.

Included within Contract system envelope is £4.924m (2023/24: £2.919m) relating to additional pension contribution.

### Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2024/25	2023/24
	£000	£000
Income recognised this year	6	-
Cash payments received in-year	6	-

### Note 4 Other operating income (Group)

	2024/25			2023/24		
	Contract income	Non- contract income	Total	Contract income	Non- contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	762	-	762	529	-	529
Education and training	3,738	-	3,738	3,100	-	3,100
Income in respect of employee benefits accounted on a gross basis	1,275		1,275	1,084		1,084
Charitable fund incoming resources		107	107		195	195
Other income	3,870	-	3,870	1,264	-	1,264
<b>Total other operating income</b>	<b>9,645</b>	<b>107</b>	<b>9,752</b>	<b>5,977</b>	<b>195</b>	<b>6,172</b>

#### Of which:

Related to continuing operations	9,752	6,172
Related to discontinued operations	-	-

The 'Other income' category includes a small number of service-related income streams, primarily from arrangements with other NHS or healthcare bodies for the delivery or support of clinical services.

### Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Opening and closing balances for contract receivables and contract liabilities are presented in Notes 23 and 27 respectively. No material revenue was recognised in 2024/25 in relation to performance obligations satisfied in previous periods.

The Trust recognises income under contracts with customers in line with the satisfaction of performance obligations, which typically occurs at the point of delivery of services. Payments are generally received on agreed schedules from commissioners and other contracting bodies, with no significant financing components.

Contract receivable and contract liability balances may vary due to the timing of service delivery and commissioner settlements. No significant changes in contract asset or liability balances occurred during the reporting period.

Revenue from NHS contracts is typically subject to fixed or variable consideration, with variable elements constrained in line with the NHS Payment Scheme rules and IFRS 15 guidance.

#### Note 5.1 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services

that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
Income from services designated as commissioner requested services	145,095	131,591
Income from services not designated as commissioner requested services	<u>5,287</u>	<u>4,115</u>
<b>Total</b>	<b><u>150,382</u></b>	<b><u>135,706</u></b>

#### **Note 5.2 Profits and losses on disposal of property, plant and equipment**

There are no profits or loss on disposal of property, plant and equipment during the year.

#### **Note 6 Operating expenses (Group)**

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
Purchase of healthcare from NHS and DHSC bodies	4,388	4,684
Purchase of healthcare from non-NHS and non-DHSC bodies	28,743	25,670
Staff and executive directors' costs	86,020	79,072
Remuneration of non-executive directors	153	151
Supplies and services - clinical (excluding drugs costs)	2,517	2,228
Supplies and services - general	1,162	1,022
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,603	1,922
Consultancy costs	215	152
Establishment	1,576	1,568
Premises	6,316	6,624
Transport (including patient travel)	110	115
Depreciation on property, plant and equipment	5,665	5,507
Amortisation of intangible assets	342	382
Net impairments	(4)	346
Movement in credit loss allowance: contract receivables / contract assets	408	93
Increase/(decrease) in other provisions	1,855	-
Change in provisions discount rate(s)	21	(106)
Fees payable to the external auditor		
audit services- statutory audit	160	142
Internal audit costs	139	121
Clinical negligence	2,311	2,373
Legal fees	114	45
Insurance	176	168
Research and development	223	31
Education and training	494	546
Expenditure on low value leases	928	1,294
Car parking & security	175	148
Hospitality	1	-
Losses, ex gratia & special payments	38	2
Other services, e.g. external payroll	341	221
Other NHS charitable fund resources expended	240	308
Other	<u>4,909</u>	<u>4,858</u>
<b>Total</b>	<b><u>151,339</u></b>	<b><u>139,687</u></b>

**Of which:**

Related to continuing operations	151,339	139,687
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The 'Other' expenditure category comprises a range of operational costs not classified elsewhere, including contracted support for clinical and corporate functions. These costs reflect ongoing service delivery needs and the Trust's broader operational model.

#### Note 6.1 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2023/24: £1 million). Expenditure is disclosed net of irrecoverable VAT. Where VAT is irrecoverable the gross cost is disclosed.

Note 7 Impairment of assets (Group)	2024/25	2023/24
	£000	£000
<b>Net impairments charged to operating surplus / deficit resulting from:</b>		
Changes in market price	(4)	346
<b>Total net impairments charged to operating surplus / deficit</b>	<b>(4)</b>	<b>346</b>
Impairments charged / reversals taken to the revaluation reserve	(830)	2814
<b>Total net impairments</b>	<b>(834)</b>	<b>3160</b>

All impairments of assets relate to the Trust actives; there are no impaired assets for the Charity.

#### Note 7.1 Revaluation of Assets (Group)

	2024/25	2023/24
	£000	£000
<b>Opening Revaluation Reserve as at 1 April</b>	1,499	3,356
Net Impairments / reversals	830	(2,814)
Revaluations	-	957
<b>Closing Revaluation Reserve as at 31 March</b>	<b>2,329</b>	<b>1,499</b>

The impairments and revaluations shown above are a result of the annual revaluation of land and buildings undertaken by the valuation partners. The value of Land has decreased by £1.161m with the remaining changes relating to the revaluation of Buildings.

All impairments of assets relate to the Trust actives; there are no impaired assets for the Charity

#### Note 8 Employee benefits (Group)

	2024/25	2023/24
	Total	Total
	£000	£000
Salaries and wages	64,082	58,100
Social security costs	6,714	5,723
Apprenticeship levy	303	268
Employer's contributions to NHS pensions	12,423	9,019
Pension cost - other	12	20
Temporary staff (including agency)	2,250	5,858
NHS charitable funds staff	236	84
<b>Total gross staff costs</b>	<b>86,020</b>	<b>79,072</b>

**Note 8.1 Retirements due to ill-health (Group)**

During 2024/25 there was 1 early retirement from the trust agreed on the grounds of ill-health (none in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements are £4k (£0k in 2023/24). These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

**Note 9 Pension costs**

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

**a) Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2024, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the scheme Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

**b) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

**Note 10 Finance income (Group)**

Finance income represents interest received on assets and investments in the period.

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
Interest on bank accounts	390	366

NHS charitable fund investment income	50	47
<b>Total finance income</b>	<b>440</b>	<b>413</b>

**Note 10.1 Finance expenditure (Group)**

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2024/25	2023/24
	£000	£000
<b>Interest expense:</b>		
Interest on lease obligations	284	351
<b>Total interest expense</b>	<b>284</b>	<b>351</b>
Unwinding of discount on provisions	45	79
<b>Total finance costs</b>	<b>329</b>	<b>430</b>

**Note 11 Other gains (Group)**

	2024/25	2023/24
	£000	£000
Gains on termination of finance leases (lessor)	-	1
<b>Total other gains</b>	<b>-</b>	<b>1</b>

**Note 12 Trust income statement and statement of comprehensive income**

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's (deficit) for the period was (£495) thousand (2023/24: £3.695 million). The trust's total comprehensive income/(expense) for the period was (£1.717) million (2023/24: (£5,113) million).

**Note 13 Intangible assets (Group)**

All intangible assets within the Group are related to the Foundation Trust, none are related to the Charity.

Intangible assets are amortised on a straight-line basis over their expected useful lives, which range from 3 to 7 years.

<b>Note 13.1 Intangible assets -2024/25Group</b>	<b>Software licences</b>	<b>Total</b>
	£000	£000
<b>Valuation / gross cost at 1 April 2024 - brought forward</b>	<b>4,022</b>	<b>4,022</b>
Additions	294	294
<b>Valuation / gross cost at 31 March 2025</b>	<b>4,316</b>	<b>4,316</b>
<b>Amortisation at 1 April 2024 - brought forward</b>	<b>3,041</b>	<b>3,041</b>
Provided during the year	342	342
<b>Amortisation at 31 March 2025</b>	<b>3,383</b>	<b>3,383</b>
<b>Net book value at 31 March 2025</b>	<b>933</b>	<b>933</b>
<b>Net book value at 1 April 2024</b>	<b>981</b>	<b>981</b>

All intangible assets within the Group are related to the Foundation Trust., none are related to the Charity

**Note 13.2 Intangible assets - 2023/24**

<b>Group</b>	<b>Software licences</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>
<b>Valuation / gross cost at 1 April 2023 – brought forward</b>	<b>3,998</b>	<b>3,998</b>
Additions	24	24
<b>Valuation / gross cost at 31 March 2024</b>	<b>4,022</b>	<b>4,022</b>
<b>Amortisation at 1 April 2023 - as previously stated</b>	<b>2,659</b>	<b>2,659</b>
Provided during the year	382	382
<b>Amortisation at 31 March 2024</b>	<b>3,041</b>	<b>3,041</b>
<b>Net book value at 31 March 2024</b>	<b>981</b>	<b>981</b>
<b>Net book value at 1 April 2023</b>	<b>1,339</b>	<b>1,339</b>

## Note 14 Property, plant and equipment 2024/25

## Note 14.1 Property, plant and equipment – 31 March 2024/25

Depreciation on all asset classes except Land, to which it is not applied, is calculated on a straight-line basis.

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
<b>Valuation/gross cost at 1 April 2024 - brought forward</b>	<b>6,025</b>	<b>33,935</b>	<b>611</b>	<b>985</b>	<b>17,028</b>	<b>84</b>	<b>8,919</b>	<b>181</b>	-	<b>67,768</b>
Additions	-	27	3	2,690	1,555	-	1,552	-	-	<b>5,827</b>
Impairments	(1,161)	(2,650)	(331)	-	-	-	-	-	-	<b>(4,142)</b>
Reversals of impairments	-	4,976	-	-	-	-	-	-	-	<b>4,976</b>
Revaluations	-	(962)	(24)	-	-	-	-	-	-	<b>(986)</b>
Reclassifications	-	2,691	-	(2,707)	-	-	-	16	-	-
<b>Valuation/gross cost at 31 March 2025</b>	<b>4,864</b>	<b>38,017</b>	<b>259</b>	<b>968</b>	<b>18,583</b>	<b>84</b>	<b>10,471</b>	<b>197</b>	-	<b>73,443</b>
<b>Accumulated depreciation at 1 April 2024 - brought forward</b>	-	<b>20</b>	-	-	<b>11,998</b>	<b>47</b>	<b>6,122</b>	<b>108</b>	-	<b>18,295</b>
Provided during the year	-	972	24	-	988	9	677	9	-	<b>2,679</b>
Revaluations	-	(962)	(24)	-	-	-	-	-	-	<b>(986)</b>
<b>Accumulated depreciation at 31 March 2025</b>	-	<b>30</b>	-	-	<b>12,986</b>	<b>56</b>	<b>6,799</b>	<b>117</b>	-	<b>19,988</b>
<b>Net book value at 31 March 2025</b>	<b>4,864</b>	<b>37,987</b>	<b>259</b>	<b>968</b>	<b>5,597</b>	<b>28</b>	<b>3,672</b>	<b>80</b>	-	<b>53,455</b>
<b>Net book value at 1 April 2024</b>	<b>6,025</b>	<b>33,915</b>	<b>611</b>	<b>985</b>	<b>5,030</b>	<b>37</b>	<b>2,797</b>	<b>73</b>	-	<b>49,473</b>

## Note 14.2 Property, plant and equipment - 31 March 2023/24

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
<b>Valuation / gross cost at 1 April 2023 - as previously stated</b>	<b>6,025</b>	<b>35,437</b>	<b>559</b>	<b>488</b>	<b>16,010</b>	<b>84</b>	<b>8,745</b>	<b>181</b>	<b>-</b>	<b>67,529</b>
Additions	-	821	56	1,341	1,018	-	174	-	-	3,410
Impairments	-	(4,289)	-	-	-	-	-	-	-	(4,289)
Reversals of impairments	-	1,093	36	-	-	-	-	-	-	1,129
Revaluations	-	10	(21)	-	-	-	-	-	-	(11)
Reclassifications	-	863	(19)	(844)	-	-	-	-	-	-
<b>Valuation/gross cost at 31 March 2024</b>	<b>6,025</b>	<b>33,935</b>	<b>611</b>	<b>985</b>	<b>17,028</b>	<b>84</b>	<b>8,919</b>	<b>181</b>	<b>-</b>	<b>67,768</b>
<b>Accumulated depreciation at 1 April 2023 - as previously stated</b>	<b>-</b>	<b>10</b>	<b>-</b>	<b>-</b>	<b>11,054</b>	<b>38</b>	<b>5,406</b>	<b>99</b>	<b>-</b>	<b>16,607</b>
Provided during the year	-	957	21	-	944	9	716	9	-	2,656
Revaluations	-	(947)	(21)	-	-	-	-	-	-	(968)
<b>Accumulated depreciation at 31 March 2024</b>	<b>-</b>	<b>20</b>	<b>-</b>	<b>-</b>	<b>11,998</b>	<b>47</b>	<b>6,122</b>	<b>108</b>	<b>-</b>	<b>18,295</b>
<b>Net book value at 31 March 2024</b>	<b>6,025</b>	<b>33,915</b>	<b>611</b>	<b>985</b>	<b>5,030</b>	<b>37</b>	<b>2,797</b>	<b>73</b>	<b>-</b>	<b>49,473</b>
<b>Net book value at 1 April 2023</b>	<b>6,025</b>	<b>35,427</b>	<b>559</b>	<b>488</b>	<b>4,956</b>	<b>46</b>	<b>3,339</b>	<b>82</b>	<b>-</b>	<b>50,922</b>

All Property, Plant and Equipment is held on behalf of the Trust, there are none applicable to the Charity.

**Note 14.3 Property plant and equipment financing - 31 March 2025**

The Trust does not operate any leases as a lessor

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	4,864	34,736	259	968	5,596	28	3,672	80	-	50,203
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	-	-
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	-	-
Owned - donated/granted	-	3,251	-	-	1	-	-	-	-	3,252
<b>NBV total at 31 March 2025</b>	<b>4,864</b>	<b>37,987</b>	<b>259</b>	<b>968</b>	<b>5,597</b>	<b>28</b>	<b>3,672</b>	<b>80</b>	<b>-</b>	<b>53,455</b>

**Note 14.4 Property, plant and equipment financing - 31 March 2024**

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	6,025	31,811	611	985	4,960	37	2,797	73	-	47,299
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	-	-
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	-	-
Owned - donated/granted	-	2,104	-	-	70	-	-	-	-	2,174
<b>NBV total at 31 March 2024</b>	<b>6,025</b>	<b>33,915</b>	<b>611</b>	<b>985</b>	<b>5,030</b>	<b>37</b>	<b>2,797</b>	<b>73</b>	<b>-</b>	<b>49,473</b>

**Note 15 Donations of property, plant and equipment**

There is no restriction by the Donor on the use of donated assets.

**Note 16 Revaluations of property, plant and equipment**

Land and buildings are held at current valuation as identified by a full valuation, carried out as at 31st March 2025, by a professional independent valuation specialist, Gerard Eve.

**Note 17 Leases - The Royal Orthopaedic Hospital NHS Foundation Trust as a lessee**

The Trust has entered into leases under the classifications of land - in relation to Car Parking facilities, Buildings - in relation to Modular Theatres and Equipment in relation to medical assets.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

**Note 17.1 Right of use assets 2024/25**

Group	Property (land and buildings)	Plant & machinery	Total
	£000	£000	£000
<b>Valuation / gross cost at 1 April 2024 - brought forward</b>	<b>19,087</b>	<b>2,289</b>	<b>21,376</b>
Additions	-	44	44
Remeasurements of the lease liability	421	-	421
Disposals / derecognition	-	(29)	(29)
<b>Valuation/gross cost at 31 March 2025</b>	<b>19,508</b>	<b>2,304</b>	<b>21,812</b>
<b>Accumulated depreciation at 1 April 2024 - brought forward</b>	<b>4,190</b>	<b>1,261</b>	<b>5,451</b>
Provided during the year	2,331	655	2,986
Disposals / derecognition	-	(29)	(29)
<b>Accumulated depreciation at 31 March 2025</b>	<b>6,521</b>	<b>1,887</b>	<b>8,408</b>
<b>Net book value at 31 March 2025</b>	<b>12,987</b>	<b>417</b>	<b>13,404</b>
<b>Net book value at 1 April 2024</b>	<b>14,897</b>	<b>1,028</b>	<b>15,925</b>

**Note 17.2 Right of use assets 2023/24**

Group	Property (land and buildings)	Plant & machinery	Total
	£000	£000	£000
<b>Valuation / gross cost at 1 April 2023 - brought forward</b>	<b>18,542</b>	<b>2,289</b>	<b>20,831</b>
Remeasurements of the lease liability	756	-	756
Disposals / derecognition	(211)	-	(211)
<b>Valuation/gross cost at 31 March 2024</b>	<b>19,087</b>	<b>2,289</b>	<b>21,376</b>
<b>Accumulated depreciation at 1 April 2023 - brought forward</b>	<b>2,207</b>	<b>423</b>	<b>2,630</b>
Provided during the year	2,217	634	2,851
Reclassifications	(204)	204	-
Disposals / derecognition	(30)	-	(30)
<b>Accumulated depreciation at 31 March 2024</b>	<b>4,190</b>	<b>1,261</b>	<b>5,451</b>
<b>Net book value at 31 March 2024</b>	<b>14,897</b>	<b>1,028</b>	<b>15,925</b>
<b>Net book value at 1 April 2023</b>	<b>16,335</b>	<b>1,866</b>	<b>18,201</b>

All Right of Use assets are related to the Trust none are related to the Charity

**Note 17.3 Revaluations of right of use assets**

Right of use assets, due to their recognition at the present value of future minimum lease payments are not revalued with the exception of Land. Land, though leased is at a nominal peppercorn rental where the recognition of future lease payments would not reflect the true replacement cost, for this reason land is carried at revalued costs.

**Note 17.4 Reconciliation of the carrying value of lease liabilities**

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 27.

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
<b>Carrying value at 1 April</b>	<b>16,145</b>	<b>18,339</b>	<b>16,145</b>	<b>18,339</b>
Lease additions	44	-	44	-
Lease liability remeasurements	421	756	421	756
Interest charge arising in year	284	351	284	351
Early terminations	-	(182)	-	(182)
Lease payments (cash outflows)	(3,172)	(3,119)	(3,172)	(3,119)
<b>Carrying value at 31 March</b>	<b>13,722</b>	<b>16,145</b>	<b>13,722</b>	<b>16,145</b>

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments would be disclosed in Note 6, cash outflows in respect of leases recognised on the SoFP are disclosed in the reconciliation above. There is no Income generated from subleasing right of use assets.

**Note 17.5 Maturity analysis of future lease payments at 31 March 2025**

	<b>Total</b>
	<b>31 March 2025</b>
	<b>£000</b>
<b>Undiscounted future lease payments payable in:</b>	
- not later than one year;	3,059
- later than one year and not later than five years;	9,325
- later than five years.	<u>2,473</u>
<b>Total gross future lease payments</b>	<b><u>14,857</u></b>
Finance charges allocated to future periods	<u>(1,135)</u>
<b>Net lease liabilities at 31 March 2025</b>	<b><u><u>13,722</u></u></b>

**Note 17.6 Maturity analysis of future lease payments at 31 March 2024**

	<b>Total</b>
	<b>31 March 2024</b>
	<b>£000</b>
<b>Undiscounted future lease payments payable in:</b>	
- not later than one year;	3,190
- later than one year and not later than five years;	10,197
- later than five years.	<u>4,200</u>
<b>Total gross future lease payments</b>	<b><u>17,587</u></b>
Finance charges allocated to future periods	<u>(1,442)</u>
<b>Net finance lease liabilities at 31 March 2024</b>	<b><u><u>16,145</u></u></b>

All lease liabilities for the group relate to the Trust activities, there are no leases for the Charity.

**Note 18 Other investments / financial assets (non-current)**

	<b>Group</b>		<b>Trust</b>	
	<b>2024/25</b>	<b>2023/24</b>	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>Carrying value at 1 April - brought forward</b>	<b>962</b>	<b>907</b>	<b>0</b>	<b>0</b>
Movement in fair value through OCI	<u>(15)</u>	<u>55</u>	<u>0</u>	<u>0</u>
<b>Carrying value at 31 March</b>	<b><u><u>947</u></u></b>	<b><u><u>962</u></u></b>	<b><u><u>0</u></u></b>	<b><u><u>0</u></u></b>

**Note 18.1 Other investments / financial assets (current)**

	<b>Group</b>		<b>Trust</b>	
	<b>31 March</b>	<b>31 March</b>	<b>31 March</b>	<b>31 March</b>
	<b>2025</b>	<b>2024</b>	<b>2025</b>	<b>2024</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Other current financial assets	<u>211</u>	<u>164</u>	<u>0</u>	<u>0</u>
<b>Total current investments / financial assets</b>	<b><u><u>211</u></u></b>	<b><u><u>164</u></u></b>	<b><u><u>0</u></u></b>	<b><u><u>0</u></u></b>

*Note: all investments are held by the trust's associated charity which has been consolidated into these financial statements.*

**Note 18.2 Short-term investments and deposits**

The Consolidated group held short-term cash deposits within a multi-asset fund of £211,000 (2023/24: £164,000) managed by Cazenove Capital. The Trust does not hold any short-term cash deposits (2023/24: £0).

**Note 19 Analysis of charitable fund reserves**

The charitable funds shown below have all been consolidated within this set of accounts.

	31 March 2025	31 March 2024
	£000	£000
<b>Unrestricted funds:</b>		
Unrestricted income funds	585	735
<b>Restricted funds:</b>		
Other restricted income funds	998	1,269
	<u>1,583</u>	<u>2,004</u>

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

**Note 20 Inventories**

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
Consumables	-	1	-	1
<b>Total inventories</b>	<u>-</u>	<u>1</u>	<u>-</u>	<u>1</u>
<b>of which:</b>				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £1,604k (2023/24: £1,940k). Write-down of inventories recognised as expenses for the year were £0k (2023/24: £0k).

**Note 21 Receivables**

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
<b>Current</b>				
Contract receivables	16,302	5,481	16,302	5,481
Allowance for impaired contract receivables / assets	(3,986)	(3,578)	(3,986)	(3,578)
Prepayments (non-PFI)	4,381	5,918	4,381	5,918
PDC dividend receivable	68	-	68	-
VAT receivable	1,502	329	1,502	329
Other receivables	29	43	29	43
NHS charitable funds receivables	11	1	-	1
<b>Total current receivables</b>	<u>18,307</u>	<u>8,194</u>	<u>18,296</u>	<u>8,194</u>

**Of which receivable from NHS and DHSC group bodies:**

Current	10,423	2,021
Non-current	-	-

**Note 21.1 Allowances for credit losses - 2024/25**

	<b>Group</b>	
	<b>Contract receivables and contract assets</b>	<b>All other receivables</b>
	<b>£000</b>	<b>£000</b>
<b>Allowances as at 1 Apr 2024 - brought forward</b>	<b>3,578</b>	-
New allowances arising	408	-
<b>Allowances as at 31 Mar 2025</b>	<b>3,986</b>	-

**Note 21.2 Allowances for credit losses - 2023/24**

	<b>Group</b>	
	<b>Contract receivables and contract assets</b>	<b>All other receivables</b>
	<b>£000</b>	<b>£000</b>
<b>Allowances as at 1 Apr 2023 – brought forward</b>	<b>3,485</b>	-
Changes in existing allowances	93	-
<b>Allowances as at 31 Mar 2024</b>	<b>3,578</b>	-

All allowances for credit losses relate to the Trust, no allowances relate to the Charity.

**Note 22 Exposure to credit risk**

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. Normal payments by results contracts have moved to block contracts which has reduced the credit risk further in relation to public sector bodies.

The maximum exposures as at 31 March 2025 are in receivables from customers, as disclosed in note 21 Receivables note.

**Note 23 Cash and cash equivalents movements**

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	<b>Group</b>		<b>Trust</b>	
	<b>2024/25</b>	<b>2023/24</b>	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>At 1 April</b>	<b>2,583</b>	<b>8,790</b>	<b>1,699</b>	<b>7,591</b>
Net change in year	1,174	(6,207)	1,594	(5,892)
<b>At 31 March</b>	<b>3,757</b>	<b>2,583</b>	<b>3,293</b>	<b>1,699</b>
<b>Broken down into:</b>				
Cash at commercial banks and in hand	466	885	2	1
Cash with the Government Banking Service	3,291	1,698	3,291	1,698
<b>Total cash and cash equivalents as in SoFP</b>	<b>3,757</b>	<b>2,583</b>	<b>3,293</b>	<b>1,699</b>
<b>Total cash and cash equivalents as in SoCF</b>	<b>3,757</b>	<b>2,583</b>	<b>3,293</b>	<b>1,699</b>

## Note 24 Trade and other payables

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
<b>Current</b>				
Trade payables	9,692	6,923	9,692	6,923
Capital payables	1,258	676	1,258	676
Accruals	3,652	3,609	3,652	3,609
Other taxes payable	1,685	1,718	1,685	1,718
PDC dividend payable	114	-	114	-
Pension contributions payable	1,072	970	1,072	970
Other payables	478	-	478	-
NHS charitable funds: trade and other payables	50	7	-	7
<b>Total current trade and other payables</b>	<b>18,001</b>	<b>13,903</b>	<b>17,951</b>	<b>13,903</b>
<b>Non-current</b>	-	-	-	-
<b>Total non-current trade and other payables</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>Of which payables from NHS and DHSC group bodies:</b>				
Current	3,777	3,909		
Non-current	-	-		

## Note 25 Early retirements in NHS payables above

There was 1 early retirement for ill health recorded at a cost of £4k for the Trust. (2023/24 nil).

## Note 26 Other liabilities

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
<b>Current</b>				
Deferred income: contract liabilities	6,332	1,233	6,332	1,233

## Note 27 Borrowings

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
<b>Current</b>				
Lease liabilities	2,888	3,190	2,888	3,190
<b>Total current borrowings</b>	<b>2,888</b>	<b>3,190</b>	<b>2,888</b>	<b>3,190</b>
<b>Non-current</b>				
Lease liabilities	10,834	12,955	10,834	12,955
<b>Total non-current borrowings</b>	<b>10,834</b>	<b>12,955</b>	<b>10,834</b>	<b>12,955</b>

**Note 27.1 Reconciliation of liabilities arising from financing activities (Group)**

<b>Group - 2024/25</b>	<b>Lease liabilities</b>
	<b>£000</b>
<b>Carrying value at 1 April 2024</b>	<b>16,145</b>
<b>Cash movements:</b>	
Financing cash flows - payments and receipts of principal	(2,888)
Financing cash flows - payments of interest	(284)
<b>Non-cash movements:</b>	
Additions	44
Lease liability remeasurements	421
Application of effective interest rate	284
<b>Carrying value at 31 March 2025</b>	<b>13,722</b>

<b>Group - 2023/24</b>	<b>Lease liabilities</b>
	<b>£000</b>
<b>Carrying value at 1 April 2023</b>	<b>18,339</b>
<b>Cash movements:</b>	
Financing cash flows - payments and receipts of principal	(2,768)
Financing cash flows - payments of interest	(351)
<b>Non-cash movements:</b>	
Lease liability remeasurements	756
Application of effective interest rate	351
Early terminations	(182)
<b>Carrying value at 31 March 2024</b>	<b>16,145</b>

All lease liabilities for the group relate to Trust activities, there are no leases relating to the Charity.

**Note 27.2 Provisions for liabilities and charges analysis (Group)**

<b>Group</b>	<b>Pensions: injury benefits</b>	<b>Legal claims</b>	<b>Other</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>At 1 April 2024</b>	<b>156</b>	<b>12</b>	<b>1,019</b>	<b>1,187</b>
Change in the discount rate	-	-	21	21
Arising during the year	-	-	1,855	1,855
Utilised during the year	(26)	-	-	(26)
Reversed unused	-	-	(68)	(68)
Unwinding of discount	20	-	25	45
<b>At 31 March 2025</b>	<b>150</b>	<b>12</b>	<b>2,852</b>	<b>3,014</b>
<b>Expected timing of cash flows:</b>				
- not later than one year;	-	-	1,833	1,833
- later than one year and not later than five years;	-	12	664	676
- later than five years.	150	-	355	505
<b>Total</b>	<b>150</b>	<b>12</b>	<b>2,852</b>	<b>3,014</b>

All Group provisions relate to Trust activities; there are no provisions relating to the Charity.

The provisions included under legal claims are for employee and public liability and are subject to changes in value and timing by either third party insurers or NHS Resolution depending on the incident date.

Early retirement provisions are discounted using HM Treasury's pension discount rate. All Other claims are discounted using the real discount rate set by HM Treasury.

The Trust holds provisions for a small number of obligations where there is uncertainty around the timing and value of any potential outflow. Only one class of provision is considered material, and this relates to general operational and employment-related matters. This provision is based on management's best estimate and reflects the current stage of discussions and outcomes. Other provisions, including injury benefits and legal claims, are not individually material and are based on known obligations or established schemes. These are reviewed regularly and updated to reflect new information where applicable. No reimbursements are expected for any of the recognised provisions. No contingent liabilities have been identified at the reporting date.

### Note 27.3 Clinical negligence liabilities

At 31 March 2025, £11,695k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Royal Orthopaedic Hospital NHS Foundation Trust (31 March 2024: £10,145k). note 1.14.

### Note 28 Contractual capital commitments

	Group	
	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	2,293	2,086
Intangible assets	-	146
<b>Total</b>	<b>2,293</b>	<b>2,232</b>

All contractual capital commitments for the group relate to the Trust, there are no contractual commitments for the Charity.

### Note 28.1 Financial risk management

The Royal Orthopaedic Hospital NHS Foundation Trust seeks to minimise its financial risks and through its treasury management policy, does not buy or sell financial instruments. Trust treasury activity is subject to review by the Trust's internal auditor on a rotational basis.

#### Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

#### Interest Rate Risk

The Foundation Trust's financial assets and financial liabilities carry nil or fixed rates of interest. The Foundation Trust is not, therefore, exposed to significant interest-rate risk.

#### Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. Due to COVID-19 normal payments by results contracts have moved to block contracts which has reduced the credit risk further in relation to public sector bodies.

The maximum exposures as at 31 March 2025 are in receivables from customers, as disclosed in the Trade Receivables note 23.

#### Liquidity Risk

The Trust's operating costs are incurred under contracts with NHS Clinical Commissioning Groups, who are financed annually from resources voted by Parliament. Such contracted income is received in accordance with the NHS funding mechanism Payments by Results with payments of one twelfth of the contract value made monthly and a quarterly adjustment made to bring payments in line with actual activity. The Trust aims to fund capital schemes by internally generated funds. In addition, the Trust can borrow from the Department of Health's financing facility or commercially. The Trust is therefore not exposed to significant liquidity risk.

**Note 29 Carrying values of financial assets (Group)**

	Held at amortised cost
	£000
<b>Carrying values of financial assets as at 31 March 2025</b>	
Trade and other receivables excluding non-financial assets	10,160
Cash and cash equivalents	3,293
Consolidated NHS Charitable fund financial assets	1,633
<b>Total at 31 March 2025</b>	<b>15,086</b>

	Held at amortised cost
	£000
<b>Carrying values of financial assets as at 31 March 2024</b>	
Trade and other receivables excluding non-financial assets	1,757
Cash and cash equivalents	1,699
Consolidated NHS Charitable fund financial assets	2,011
<b>Total at 31 March 2024</b>	<b>5,467</b>

**Note 29.1 Carrying values of financial assets (Trust)**

	Held at amortised cost
	£000
<b>Carrying values of financial assets as at 31 March 2025</b>	
Trade and other receivables excluding non-financial assets	10,160
Cash and cash equivalents	3,293
<b>Total at 31 March 2025</b>	<b>13,453</b>

	Held at amortised cost
	£000
<b>Carrying values of financial assets as at 31 March 2024</b>	
Trade and other receivables excluding non-financial assets	1,757
Cash and cash equivalents	1,699
<b>Total at 31 March 2024</b>	<b>3,456</b>

**Note 29.2 Fair values of financial liabilities (Group)**

	Held at amortised cost
	£000
<b>Carrying values of financial liabilities as at 31 March 2025</b>	
Obligations under leases	13,722
Trade and other payables excluding non-financial liabilities	14,900
<b>Total at 31 March 2025</b>	<b>28,622</b>

	Held at amortised cost
	£000
<b>Carrying values of financial liabilities as at 31 March 2024</b>	
Obligations under leases	16,145
Trade and other payables excluding non-financial liabilities	10,307
<b>Total at 31 March 2024</b>	<b>26,452</b>

It is considered that the book value equates to the fair value.

**Note 29.3 Maturity of financial liabilities**

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group	
	31 March 2025	31 March 2024
	£000	£000
In one year or less	17,959	13,497
In more than one year but not more than five years	9,325	10,197
In more than five years	2,473	4,200
<b>Total</b>	<b>29,757</b>	<b>27,894</b>

All financial liabilities for the group relate to the Trust, there are no financial liabilities relating to the Charity.

**Note 30 Losses and special payments**

	2024/25		2023/24	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
<b>Group and trust</b>				
<b>Losses</b>				
Bad debts and claims abandoned	-	-	2	-
<b>Total losses</b>	<b>-</b>	<b>-</b>	<b>2</b>	<b>-</b>
<b>Special payments</b>				
Compensation under court order or legally binding arbitration award	11	37	-	-
Ex-gratia payments	29	1	6	2
<b>Total special payments</b>	<b>40</b>	<b>38</b>	<b>6</b>	<b>2</b>
<b>Total losses and special payments</b>	<b>40</b>	<b>38</b>	<b>8</b>	<b>2</b>

**Note 31 Gifts**

No gifts were received by the trust during the year.

**Note 32 Related parties**

The Royal Orthopaedic Hospital NHS Foundation Trust is a public benefit corporation which was established under the granting of authority by the independent regulator for Foundation Trusts, Monitor (now NHS Improvement) on February 1, 2007.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with The Royal Orthopaedic Hospital NHS Foundation Trust.

The remuneration of the Trust's Executive Directors, who are considered to be the key management personnel, is disclosed in full within the Remuneration Report. This includes total compensation and the breakdown by category as required under IAS 24.

The consolidated group's ultimate controlling party is the Department of Health and Social Care.

During the year The Royal Orthopaedic Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. These entries are listed below.

Under IAS 24 entities which are related parties because they are under the same governmental control are permitted to give reduced disclosures on those transactions. This note has therefore been prepared under this basis.

The Trust has had material dealings with the following bodies during 2024/25:

Birmingham Community Healthcare NHS Foundation Trust  
Birmingham Women's and Children's NHS Foundation Trust  
Cambridge University Hospitals NHS Foundation Trust  
Guy's & St Thomas' NHS Foundation Trust  
Lancashire Teaching Hospitals NHS Foundation Trust  
Milton Keynes University Hospital NHS foundation Trust  
Nottinghamshire Healthcare NHS Foundation Trust  
Oxford Health NHS Foundation Trust  
Sheffield Children's NHS Foundation Trust  
Somerset NHS Foundation Trust  
The Robert Jones and Agnus Hunt Orthopaedic Hospital NHS Foundation Trust  
The Royal Marsden NHS Foundation Trust  
University Hospitals Birmingham NHS Foundation Trust  
University Hospitals of Derby and Burton NHS Foundation Trust  
University Hospitals Sussex NHS Foundation Trust  
West Midlands Ambulance Service University NHS Foundation Trust  
Imperial College NHS Healthcare NHS Trust  
Mersey and West Lancashire Teaching Hospitals NHS Trust  
North Bristol NHS Trust  
Portsmouth Hospitals University NHS Trust  
Royal National Orthopaedic Hospitals NHS Trust  
Sandwell and West Birmingham Hospitals NHS trust  
Shrewsbury and Telford Hospitals NHS Trust  
The Royal Wolverhampton NHS Trust  
University Hospitals Coventry and Warwickshire NHS Trust  
NHS Bath and North East Somerset, Swindon and Wiltshire ICB  
NHS Bedfordshire, Luton and Milton Keynes ICB  
NHS Birmingham and Solihull ICB  
NHS Black Country ICB  
NHS Bristol, North Somerset and South Gloucestershire ICB  
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB  
NHS Cambridge and Peterborough ICB  
NHS Cheshire and Merseyside ICB  
NHS Cornwall and the Isles of Scilly ICB  
NHS Coventry and Warwickshire ICB  
NHS Derby and Derbyshire ICB  
NHS Devon ICB  
NHS Dorset ICB  
NHS Gloucestershire ICB  
NHS Greater Manchester ICB  
NHS Hampshire and the Isle of Wight ICB  
NHS Herefordshire and Worcestershire ICB  
NHS Hertfordshire and West Sussex ICB  
NHS Humber and North Yorkshire ICB  
NHS Kent and Medway ICB  
NHS Lancashire and South Cumbria ICB  
NHS Leicester, Leicestershire and Rutland ICB  
NHS Lincolnshire ICB  
NHS Mid and South Essex ICB  
NHS Norfolk and Waverley ICB  
NHS North central London  
NHS North East and North Cumbria ICB  
NHS North East London ICB  
NHS North West London ICB  
NHS Northampton ICB  
NHS Nottingham and Nottinghamshire ICB  
NHS Shropshire and Telford and Wrekin ICB  
NHS Somerset ICB  
NHS South East London ICB  
NHS South West London ICB  
NHS South Yorkshire ICB  
NHS Staffordshire and Stoke-on-Trent ICB  
NHS Suffolk and North East Essex ICB  
NHS Surrey Heartlands ICB  
NHS Sussex ICB  
NHS West Yorkshire ICB

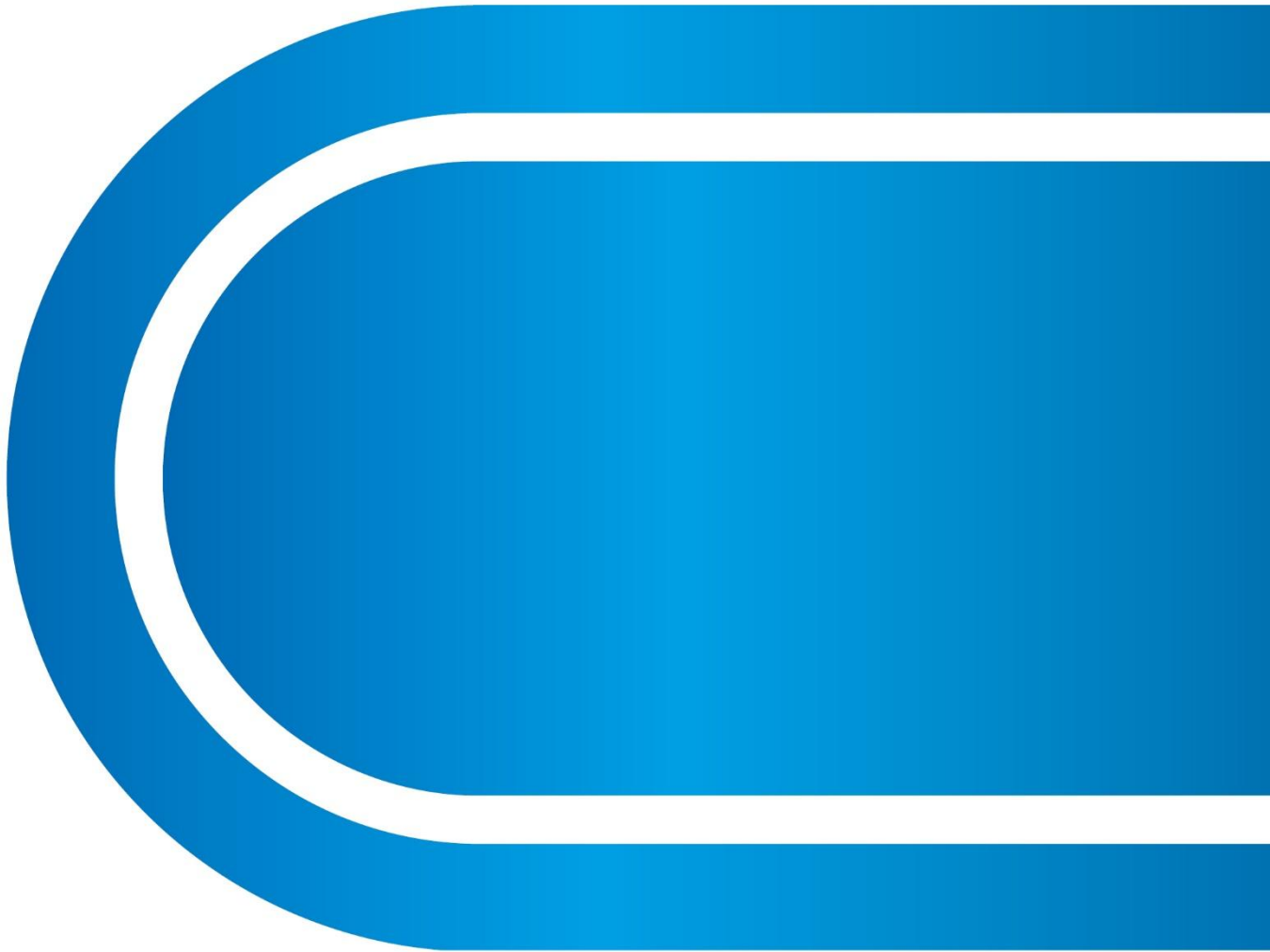
NHS England  
NHS Business Services Authority  
NHS Resolution  
Care Quality Commission  
Human Tissue Authority  
Department of Health and Social Care  
Department for Work and Pensions  
NH Revenue and Customs  
NHS Pension Scheme  
NHS Blood and Transplant  
Cabinet Office  
Royal Orthopaedic Hospital NHS Foundation Trust Charity

The Trust has also received revenue payments from the associated charitable funds where the Trustees are also members of the NHS Trust Board. The Trust charged the charity for finance administration services totalling £79k during the year (2023/24: £113k).

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**The Royal  
Orthopaedic Hospital**  
NHS Foundation Trust



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